# MEDICARE VOLUME PERFORMANCE STANDARD SYSTEM; PHYSICIAN UPDATE FOR 1992; AND INCREASES IN THE VOLUME OF MEDICARE PHYSICIAN SERVICES

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

MAY 21, 1991

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# CONTENTS


Page

Press release of Monday, May 13, 1991, announcing the hearing ..... 2

WITNESSES

U.S. Department of Health and Human Services, Gail R. Wilensky, Ph.D., Administrator, Health Care Financing Administration ..... 7

Physician Payment Review Commission, Philip R. Lee, M.D., Chairman, and Paul B. Ginsburg, Ph.D., Executive Director ..... 32

American College of Physicians, J. Harold Morris, Jr., M.D., and Howard B. Shapiro, Ph.D ..... 53

American College of Surgeons, Paul A. Ebert, M.D ..... 47

American Medical Association, Jerald R. Schenken, M.D ..... 61

SUBMISSIONS FOR THE RECORD

American College of Cardiology, statement ..... 79

Digestive Disease National Coalition, statement ..... 88

Renal Physicians Association, statement and attachment ..... 89

# MEDICARE VOLUME PERFORMANCE STANDARD SYSTEM; PHYSICIAN UPDATE FOR 1992; AND INCREASES IN THE VOLUME OF MEDICARE PHYSICIAN SERVICES

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TUESDAY, MAY 21, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, DC.*

The subcommittee met, pursuant to call, at 1:10 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, MAY 13, 1991

PRESS RELEASE #10
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
THE MEDICARE VOLUME PERFORMANCE STANDARD SYSTEM,
THE PHYSICIAN UPDATE FOR 1992, AND
INCREASES IN THE VOLUME OF MEDICARE PHYSICIAN SERVICES**

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The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the Medicare Volume Performance Standard system (MVPS), the physician update for 1992, and increases in the volume of Medicare physician services. The hearing will be held on Tuesday, May 21, 1991, beginning at 1:00 p.m. in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated, "Controlling growth in the volume of physician services is one of the most important issues facing the Medicare program. The Medicare Volume Performance Standard system represents an important first step in developing policies to control volume."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

**BACKGROUND**

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) established the MVPS system. Under this policy, an annual target rate of growth in expenditures for physician services would be established. Beginning in 1991, separate targets are set for surgical and non-surgical services.

If expenditures are below the standard, the physician services update for the following calendar year would be increased. If expenditures grow more than the standard, the update would be reduced. The maximum amount the update may be reduced without additional legislation is two percent in 1992, increasing to three percent by 1996.

The cost of Medicare physician services grew by 12.1 percent annually between 1986 and 1989. About 2.7 percent of this growth was due to increases in price, 1.1 percent to increases in the number of beneficiaries, and 7.9 percent to increases in the volume and mix of services per beneficiary.

The highest growth in volume per year between 1986 and 1989 was for certain medical services, including ophthalmology visits (18 percent), medical procedures (17 percent), laboratory services (16 percent), and cardiology services (13 percent).

During this same period, the overall volume of surgical services increased 7.4 percent per year. However, for some surgical procedures (laser procedures secondary to cataract surgery, and arthroscopies), volume grew in excess of 20 percent per year. While the volume of cataract surgery grew rapidly in the early 1980s, its volume increased by only 7.3 percent per year between 1986 and 1989.

(MORE)

The actual rate of growth in expenditures for physician services during fiscal year 1990 was 10.6 percent, exceeding the 9.1 percent MVPS standard set in OBRA 1989 by 1.5 percent.

The Secretary of Health and Human Services has recommended that the January 1992 update be reduced by 1.9 percent. Based on current estimates, this would reduce the update from 4.1 percent to 2.2 percent. This reduction includes the 1.5 percent that expenditures exceeded the fiscal year 1990 target, and the additional 0.4 percent reduction included in the Omnibus Budget Reconciliation Act of 1990. The Physician Payment Review Commission (PhysPRC) agrees with this recommendation. The 1.9 percent reduction in the update will automatically go into effect, unless changed by legislation.

For fiscal year 1992, the Secretary has recommended an overall MVPS target rate of growth of 6.2 percent. PhysPRC has reviewed this proposal and is recommending an overall target of 8.6 percent. In the absence of additional legislation this year, the target will be set by a formula in accordance with Section 1848(f) of the Social Security Act. The default target currently is estimated to be 9.1 percent.

In addition, the Secrecary has recommended separate targets of 4.1 percent for surgical services and 7.1 percent for nonsurgical services. PhysPRC is recommending targets that are 2.5 percent higher -- 6.6 percent for surgical services and 9.6 percent for non-surgical services.

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, June 4, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good afternoon.

The Committee on Ways and Means Subcommittee on Health will begin this afternoon to consider the recommendations of the administration on the Physician Payment Review Commission regarding the levels of the Medicare volume performance standards for fiscal year 1992 and the January 1992 update for physician services.

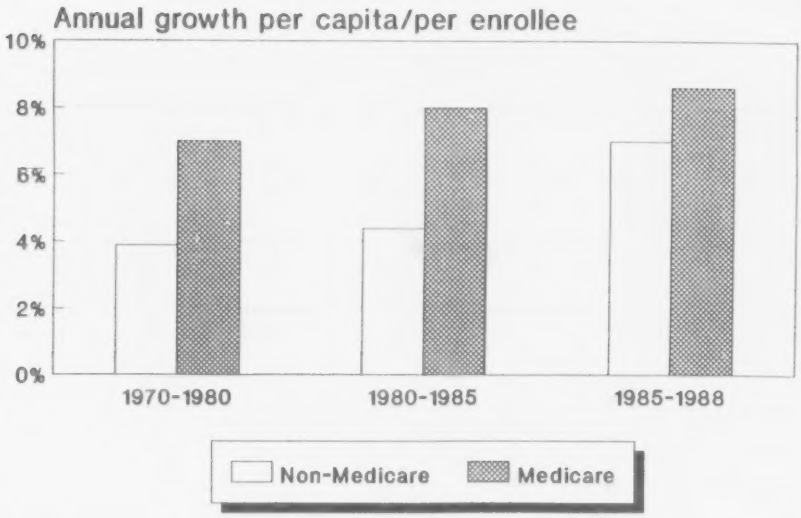
Rapid growth in part B expenditures and in the volume of physician services remain the most—or one of the most intractable problems facing Medicare. At the current rate of growth, part B expenditures are doubling every 5 years. My math tells me that is 15 percent compounded.

Growth in the volume of services per beneficiary accounts for about half of the growth in program costs. In 1990, the average Medicare patient received twice as many physician services as he or she did in 1980.

On the attached graphs to my opening statement, which are available in great quantity on the side table and for sale at a modest fee elsewhere, it shows that real growth in physician spending accelerated in both the public and private sectors. In contrast, Medicare spending for hospitals in the same period has been relatively well controlled.

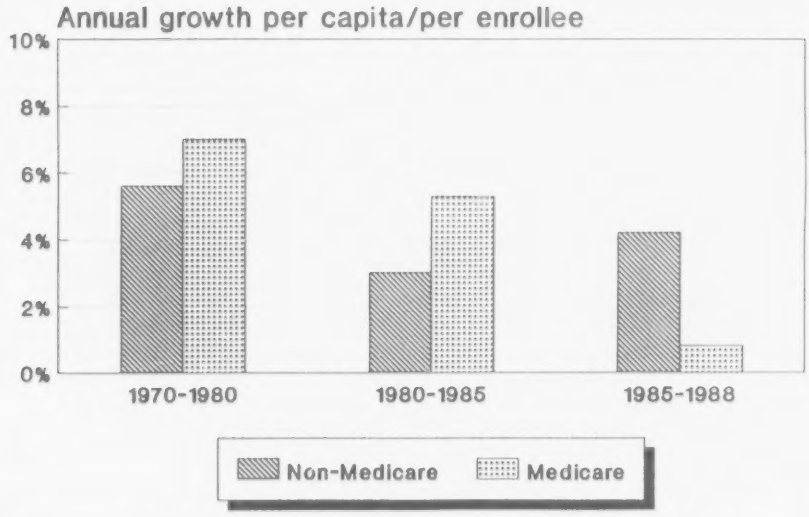
[The graphs referred to follow:]

## Real Growth in Physician Expenditures 1970-1988




Source: Based on data from HCFA

## Real Growth in Hospital Expenditures 1970-1988




Source: Based on data from HCFA

Chairman STARK. The Medicare Volume Performance Standard system, enacted as part of the physician payment reform package in OBRA 1989, represents a first step in developing a response to the volume problem.

The central feature of this system is an incentive to encourage physicians to slow the growth in volume. Hopefully, lower volume would be rewarded with higher updates.

We are now nearing the completion of the first cycle, and the report card gives us mixed results.

Congress set a modest goal for fiscal year 1990, a reduction of only one-half percent in the base line rate of growth in expenditures. According to the Department of Health and Human Services, actual growth in 1990 was a full percentage point above the base line, so we were off by more than just windage, but we were off by 1.5 percent.

Testimony presented before this subcommittee over the past year has described a wide range of activities by professional societies to develop methods to assure appropriate use of services. Hopefully, the MVPS system will provide the incentives necessary for these efforts to be successful.

Based on the first year's experience, a great deal of work remains to be done.

Controlling growth in the volume of services must be among our highest priorities. The issues relating to the growth in volume are very complex. I would like to assure all of the witnesses that their comments will help the subcommittee to understand the issues and to carry out its task of setting the 1992 update and the MVPS targets.

I would also like to suggest that all of the prepared statements of today's witnesses will appear in the record in their entirety.

Mr. McGrath, do you have a statement?

Mr. MCGRATH. Thank you, Mr. Chairman.

I don't have a formal opening statement. I would just like to welcome Dr. Wilensky and our other panelists. I am sure it is going to be an interesting hearing. We exceeded the target last year. I hope we can address, to some extent, how that would affect future targets in the following fiscal years to see what the effect this would have on quality patient care.

Thank you.

Chairman STARK. Thank you. Mr. Moody.

Mr. MOODY. My opening statement will stand as moot testimony to the urgency of getting on with the stellar presentation of our witnesses.

Chairman STARK. Our first witness is Dr. Gail Wilensky, the Administrator of the Health Care Financing Administration. Welcome.

As for all the witnesses, you may summarize, expand on your testimony, or enlighten us in any manner you choose.

**STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. WILENSKY. Thank you. Mr. Chairman, and members of the subcommittee, I am here today to discuss the administration's recommendation for the fiscal year 1992——

Chairman STARK. Gail, excuse me. You have to put that almost in your mouth. You have to swallow it.

Ms. WILENSKY. It is not on.

Mr. Chairman, and members of the subcommittee, I am here today to discuss the administration's recommendations for the fiscal year 1992 volume performance standard and the calendar year 1992 payment update. The law requires the Secretary to recommend both the performance standard and the payment update amount annually to Congress. As I discuss our recommendations, we should keep in mind that Medicare physician spending continues to grow at unacceptably high rates.

Between 1984 and 1990, Medicare physician expenditures grew at an average of nearly 12 percent per year. We project physician expenditures will continue to grow 11 percent per year, or nearly 70 percent, over the next 5 years. The cost of Medicare physician spending exerts tremendous pressure on the Federal budget.

The Medicare volume performance standard was designed to constrain the growth in physician expenditures. The performance standard sets an appropriate rate of increase against which actual expenditures are measured. The success or failure of meeting the performance standard is reflected in the fee schedule update 2 years later.

Our recommendation for the fiscal year 1992 performance standard is 6.2 percent for all physician services—4.1 percent for surgical services, and 7.1 percent for nonsurgical services.

In making the performance standard recommendation, the Secretary must consider inflation, increased enrollment, the aging of beneficiaries, technology, access to services, and the appropriate utilization of services.

We estimate the effect of inflation for fiscal year 1992 to be 2.1 percent of all physician services.

The increasing number of Medicare beneficiaries adds 1.3 percentage points.

The aging of the Medicare population adds 0.1 percentage points.

In addition, we are recommending an allowance of 3.7 percentage points to account for technology, access, and utilization for both surgical and nonsurgical services. This is one-half of the 7.4 percent estimated annual growth in expenditures between fiscal years 1986 and 1990, in excess of what is attributable to inflation, enrollment, and aging.

A quantitative factor for technology has not been separately identified. A recent study found that no method adequately measures the impact of aggregate technological change on physician expenditures.

The study also concluded that increases in the performance standard to account for technology, regardless of its cost effective-

ness, does not encourage accountability at the individual physician level.

While access may be a problem in certain areas, we do not have evidence of a national problem of access to care for Medicare beneficiaries. One measure of access is the willingness of physicians to accept the Medicare allowance as payment in full.

Physician participation is now at an all-time high. I am pleased to announce the results of the most recent participating physician enrollment cycle. Almost 48 percent of all physicians signed participation agreements. Over 85 percent of all physician bills are now paid under assignment.

An overall level of inappropriate utilization is difficult to estimate reliably. Research has identified levels of inappropriate care anywhere from 10 to 30 percent. However, most of this research has been procedure specific and does not generalize well to all Medicare services.

The Department has undertaken major efforts to identify inappropriate utilization and the effectiveness of Medicare services. Outcomes research, the development and dissemination of practice guidelines, and geographic variation analysis will ultimately lead to improvements in the practicing of medicine.

Our performance standard recommendation also considers the impact of OBRA 1990 and the implementation of the physician fee schedule.

The recommended performance standard of 6.2 percent for all physician services is derived by multiplying the effect of these factors.

As part of the payment reform, the performance standard was established as a collective incentive for the physician community to moderate increases in volume and intensity of services. However, it is a very limited tool. The volume performance standard has little influence on individual physician behavior. We need to develop more direct incentives for physicians to control the volume and intensity of their services.

We are recommending a fee schedule update for 1992 of 2.2 percent for all physician services.

In making the update recommendation, the Secretary must consider the change in the MEI, the difference between the growth in actual physician expenditures and the 1990 performance standard, changes in the volume and intensity of services, and access to services.

Our estimate of the actual growth in physician services for fiscal year 1990 is 10.6 percent. This is 1.5 percentage points higher than the 1990 performance standard of 9.1 percent.

There is no need for further adjustments to account for volume and intensity because the 1990 performance standard includes these changes. Separate factors for inappropriate utilization and access were not included because of the difficulties I have just mentioned in adequately quantifying their extent.

Our recommended update of 2.2 percent is derived by subtracting the difference between the 1990 performance standard and actual physician expenditures of 1.5 from the MEI of 3.7.

We are recommending the update be applied to both surgical and nonsurgical services. We were not able to evaluate the separate

performance of surgical and nonsurgical services in 1990 because of limitations in our data systems.

The single performance standard for 1990 makes separate 1992 updates inappropriate.

In closing, I would like to comment on the status of the fee schedule. We hope to have the proposed regulation on display at the Federal Register next week by the end of May. There are many issues involved in the proposed fee schedule, and I look forward to working with you and physician groups as we move forward toward its implementation.

Thank you. I would be glad to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF

GAIL R. WILENSKY, PH.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:
The Omnibus Budget Reconciliation Act of 1989 provided for Medicare physician payment reform consisting of three major elements: an annual volume performance standard which began in FY 1990; a resource-based fee schedule beginning January 1, 1992; and new balance billing limits which began on January 1, 1991 for nonparticipating physicians.

We have made significant strides in implementing various components of the payment reform. As we approach the implementation date of the physician fee schedule, the complexity and importance of our work becomes only clearer.

I am here today to discuss the Administration's recommendations for two components of the physician payment reform package -- the FY 1992 Medicare volume performance standard (MVPS) and the CY 1992 payment update.

**FY 1992 MVPS OVERVIEW**
Medicare physician expenditures have been growing at unacceptably high rates since the early 1970s. Between 1984 and 1990, physician expenditures grew at an average annual rate of nearly 12 percent. Current projections are that physician expenditures will grow 11 percent per year or nearly 70 percent over the next five years.

The MVPS gives the Medicare program a mechanism to constrain the growth of physician expenditures. The MVPS is not an expenditure target. It does not establish a cap on Medicare physician expenditures. The MVPS establishes an appropriate rate of expenditure growth, against which the actual rate of increase in expenditures is measured. The success or failure in meeting the MVPS is reflected in the fee schedule update two years later.

As required by law, the Administration recommends both the MVPS and the payment update annually to Congress. The Physician Payment Review Commission (PPRC) must also make recommendations on the MVPS and update. If Congress does not act on either of these recommendations or its own, both MVPS and the update are established by an automatic default mechanism that is set forth in the law.

**FY 1992 MVPS RECOMMENDATION**
Our recommendation for the FY 1992 MVPS is 6.2 percent for all physician services -- 4.1 percent for surgical services and 7.1 percent for nonsurgical services. These figures should be adjusted to account for any changes in pricing and benefits enacted in future legislation.

In making the MVPS recommendation the statute requires the Secretary to consider:

- Inflation;
- Changes in the number of enrollees;
- Aging of enrollees;
- Technology;
- Evidence of lack of access to Medicare physicians' services;
- Evidence of inappropriate utilization of services; and
- Other factors that the Secretary considers appropriate.

Let me briefly summarize how each factor was used in the development of the Administration's FY 1992 MVPS recommendation.

Inflation
The Medicare Economic Index (MEI) is a measure of inflation in selected factors most relevant to physicians in office practice, such as employee wages, rent, drugs and medical supplies, and malpractice insurance. Under the current physician payment system, the MEI is the maximum that prevailing charges for Medicare physicians' services can be increased. The MEI will also be used under the fee schedule.

According to our most recent economic projections, the MEI for CY 1992 will be 4.1 percent. OBRA 1990 requires that this estimate be reduced by 0.4 percentage points for 1992, giving us an estimated MEI of 3.7 percent.

In addition to the 1992 MEI increase, several other factors will have an effect on the general level of physicians' fees in FY 1992 such as:

- An adjustment for the excess of actual expenditure increases over the FY 1990 MVPS;
- The differential 1990 MEI increases mandated by OBRA 1990;
- The annual update for laboratory services; and
- The increasing number of participating physicians receiving the 5 percent higher payment than nonparticipating physicians.

When all these factors are considered, the weighted composite inflationary effect on physicians' fees in FY 1992 is estimated to be 2.1 percent for all physician services -- 2.1 percent for nonsurgical services and 2.0 percent for surgical services. However, changes in the economic projections between now and October -- when the MEI update is usually calculated -- could change our estimates.

Changes in Medicare Part B Enrollment

Changes in Medicare Part B enrollment will also affect the utilization of physician services. Part B enrollment is expected to increase by 394,000 beneficiaries or 1.3 percent for surgical and nonsurgical services. Average Medicare Part B enrollment in FY 1992 is estimated to be over 33 million. Decreasing that figure by the estimated enrollment in risk HMOs of 1.4 million results in a net figure of almost 32 million Part B enrollees in FY 1992.

Aging of the Medicare Population

The effects of aging of the Medicare population would increase physician spending by an estimated 0.1 percentage points in FY 1992.

Combined Effect of Technology, Access and Utilization

Similar to last year, we are recommending an allowance of 3.7 percentage points for growth in technology, access, and utilization for both surgical and nonsurgical services. This is one-half of the 7.4 percent estimated annual growth in expenditures between FY 1986 and FY 1990 in excess of what is attributable to inflation, enrollment and aging.

While we cannot precisely measure the impact of technology, access, and utilization on physician expenditures, we are continuing to explore reasons for such rapid growth in expenditures.

**Technology:** The costs and savings associated with specific medical innovations are difficult to identify. Determining the effect of new technology involves estimating how it impacts both new and older, more established treatments.
The emergence and diffusion of new technologies has been under study by the Health Care Financing Administration (HCFA) in cooperation with Health Economics Research, Inc. Whether or not new technologies are used as substitutes for or in addition to older technologies has significant implications in terms of costs as well as the appropriateness and effectiveness of care rendered.

The final report of this study is currently being evaluated, but preliminary review indicates that the newer technologies studied did not replace the established ones: use rates for both new and old technologies grew throughout the study.

Another study looked at the various approaches available to measure technological change and found that no approach reliably estimates the effect of technological change on Medicare physician expenditures.

This study also concluded that allowing yearly increases in physician expenditures to account for technological change regardless of the cost-effectiveness of the technology does not promote accountability at the individual physician level.

**Access to Services:** While access may be a problem in certain areas, we do not have evidence of a national problem of access to care for Medicare beneficiaries.
One measure of access to care is the willingness of physicians to accept the Medicare allowance as payment in full for services. Physician participation and assignment rates have continually increased since the inception of the physician participation program and are now at an all time high.

I am pleased to announce the results of the most recent participating physician enrollment cycle. Some 47.6 percent of physicians signed participation agreements, up from 28 percent in 1985. Services provided by participating physicians comprise 70 percent of covered charges. Physician bills paid under assignment increased to more than 85 percent between January and March of 1991.

Our proposed Current Beneficiary Survey (CBS), which is planned as an ongoing survey of Medicare beneficiaries, will provide us with relevant information regarding access and utilization. One purpose of this survey is to assess the effects of physician payment reform, including access to services, on Medicare beneficiaries. This information will be useful in considering future payment updates and MVPS rates of increase.

**Inappropriate Utilization:** Most estimates of inappropriate utilization are procedure-specific, and do not generalize well to all Medicare services. Consequently, an overall level of inappropriateness is difficult to estimate reliably.
The Department has undertaken a major effort to identify inappropriate utilization and the effectiveness of particular Medicare services. Outcomes research, the development and dissemination of practice guidelines, and geographic variation analysis will ultimately lead to improvements in the practice of medicine.

We will continue to study inappropriate utilization even though we do not anticipate being able to provide a precise estimate of its extent in the near future.

Consideration of Other Factors
Our FY 1992 recommendation considers two other factors in addition to the those required by statute: the impact of OBRA 1990 legislative changes and the effect of the physician fee schedule to be implemented on January 1, 1992.

**OBRA 1990:** OBRA 1990 is projected to result in aggregate decreases in the FY 1992 MVPS of 1.0 percentage points for nonsurgical services and 1.7 percentage points for surgical services.

The increase in the Part B deductible will reduce outlays for both nonsurgical and surgical services. Provisions such as reductions in payments for overvalued procedures and assistants-at-surgery and reductions in prevailing charges for other procedures affect surgical services. Reductions in certain prevailing charges also affect nonsurgical services.

On the other hand, provisions such as expanded coverage of screening mammography services, additional coverage of nurse

practitioner services, and changes to certified registered nurse anesthetists payments have the affect of increasing nonsurgical services.

**Impact of the Physician Fee Schedule:** Implementation of the physician fee schedule effectively changes the relative price for surgical and nonsurgical services. Nonsurgical expenditures will increase by an estimated 0.8 percentage points. Surgical expenditures will decrease by an estimated 1.2 percentage points. We have included this adjustment in our recommendation.

**CY 1992 PAYMENT UPDATE OVERVIEW**

The Secretary is required to recommend an annual physician payment update. In 1992, the update will be used to increase physician fee schedule amounts established on the basis of relative value units.

Relative value units measure the amount of resources used by physicians to provide different services. The relative values are geographically adjusted and then multiplied by a conversion factor that transforms relative values into payment amounts. The annual update is used to adjust the conversion factor and fee schedule payment amounts.

The Secretary is required to establish a conversion factor which results in total payments under the 1992 fee schedule, before the update, which are budget neutral compared to 1991 expenditures. The CY 1992 update will be applied to the budget neutral conversion factor in order to determine next year's physician payment levels.

**CY 1992 PAYMENT UPDATE RECOMMENDATION**

We are recommending a CY 1992 fee schedule update of 2.2 percent for all physician services.

In establishing the fee schedule update, the Secretary is required by statute to consider the following factors:

- The percent change in the MEI;
- Difference between the actual rate of growth in FY 1990 physician expenditures and the FY 1990 MVPS;
- Changes in volume and intensity of services;
- Access to services; and
- Other factors that may effect volume and intensity.

Let me briefly review these factors.

Percent Change in the MEI As mentioned earlier, our most recent estimate of the adjusted MEI for CY 1992 is 3.7 percent.

Growth in Actual Expenditures Relative to MVPS Our estimate of the actual growth in all physicians' services between FY 1989 and FY 1990 is 10.6 percent. This estimated growth in physician services is 1.5 percentage points more than the established FY 1990 MVPS of 9.1 percent.

Changes in Volume and Intensity The FY 1990 MVPS included estimates for changes in volume and intensity. We do not have any evidence that there should be further adjustment of the update to account for these changes.

Access and Inappropriate Utilization Difficulties with quantifying inappropriate utilization and access to services were addressed earlier in the MVPS discussion. We will continue to closely monitor utilization and access in order to identify problem areas.

Our recommended update of 2.2 percent is derived by subtracting the difference between the MVPS and the actual increase in physician expenditures of 1.5 from the MEI of 3.7.



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We are recommending the 2.2 percent update be applied to both surgical and nonsurgical services. The Secretary was required to evaluate the separate performance of surgical and nonsurgical services during FY 1990. This was not possible for FY 1990 because of the limitations of our current data systems. It would be inappropriate to recommend separate CY 1992 updates for surgical and nonsurgical services since there was a single MVPS.

**MONITORING UTILIZATION, ACCESS AND APPROPRIATENESS**

We recently submitted our first annual monitoring report to Congress on the impact of physician payment reform on utilization, access, and appropriateness. This report serves as a blueprint of all the efforts underway to monitor changes in these areas.

The report examines HCFA's ongoing research and monitoring systems. The report also details the diverse data acquisition and information management systems under development that will improve our capability to assess the impact of physician payment reform.

For instance, by the end of the year, HCFA will have restructured its claims data systems to create a single large National Claims History database that will contain information about all Medicare services paid on a fee-for-service basis. Another example is the implementation of the Uniform Clinical Data Set, which will transform Medicare's peer review program and allow us to gather, develop, and analyze extensive clinical data over time.

**FY 1992 BUDGET PROPOSALS**

In addition to payment reform, we are proposing several changes in the Administrations's FY 1992 budget to assist us in carrying out our responsibility as prudent managers of the Medicare program. These proposals would eliminate duplicate payments for services, encourage the efficient provision of care, and create a more rational basis for payment.

The proposals entail budget savings, but do not violate the budget neutral implementation of the physician fee schedule. Even if there were no fee schedule, we would be making these proposals because of their merits.

Single Fee for Anesthesia Services We propose that Medicare pay the same amount for anesthesia services, regardless of whether an anesthesiologist personally performs the anesthesia service or medically directs a certified registered nurse anesthetist (CRNA). The Medicare payment for an anesthesiologist directing a CRNA would be reduced by the amount paid to the CRNA.

We also recommend that the rates for CRNAs be revised so that they are budget neutral with respect to Medicare payments for CRNAs before the direct billing provision was enacted. The 30 percent increase in payments to CRNAs due to OBRA 1990 cannot be justified based on increased costs or a shortage of anesthesia services.

Single Fee for Surgery (Assistants-at-Surgery) We recommend that Medicare create a level playing field between surgeons who use a physician as an assistant-at-surgery and those who do not. The payment for the primary surgeon would be reduced by the payment for assistants.

We support the proposal enacted by Congress last year to reduce the amount of the separate payment for assistants-at-surgery, but we believe that the provision did not do enough to address the issue of "utilization." This proposal will remove the Federal government from making determinations about the appropriateness of using a physician as an assistant-at-surgery.

Revised MEI We are planning to implement a revised formula to

calculate the Medicare Economic Index. Regulations will be out shortly, and we plan to use the new MEI for the 1992 update.

The mandated OBRA 1986 study of the elements and methods used in establishing the MEI has been completed. The calculation of the revised MEI uses a better methodology, more practice cost elements, better data to measure practice cost changes, and a better method for dealing with productivity changes. The new methodology will use a moving average, rather than year-to-year productivity offsets, which will improve prediction of Part B expenditures by smoothing out fluctuations due to cyclical productivity swings. The revised formula will improve the index, virtually without affecting payments in the first five years.

FY 1991 MVPS Anomaly We propose to adjust the 1993 update baseline to be MEI minus 0.9 percentage points. We believe that Congress intended to achieve a reduction from the FY 1991 baseline rate of increase of 2 percentage points when setting the FY 1991 MVPS. However, Congress changed the default MVPS to be multiplicative for years after FY 1991. This creates an anomaly; the FY 1991 MVPS achieves only a 1.1 percentage point reduction from the baseline rate of increase.

If the FY 1991 MVPS were multiplicative, the overall MVPS would have been 6.4 percent, rather than the 7.3 percent with the additive model. A 0.9 percentage point adjustment to the 1993 MEI would achieve the intended baseline reduction.

Eliminate Duplicate Payment for Specimen Collection We propose to eliminate payment of specimen collection fees for in-office tests. In 1984, we inappropriately began paying specimen collection fees for tests performed in physician offices, even though the costs of such an effort were already included in the visit fee. Physicians' prevailing charges for office visits were not adjusted to reflect the separate fee.

Under the fee schedule, overhead expenses of the physician's practice will be allocated to each procedure, including office visits. This allocation will include an amount for specimen collection.

Use Efficient Rates for Radiology and Diagnostic Tests Finally, we are proposing to collect data to determine the efficient level of operation for radiology and diagnostic tests and to adjust Medicare payments accordingly.

The physician fee schedule will establish a payment system reflecting the relative resources to produce a service. However, for radiology and diagnostic tests, this is only being done for the physician "work" component (i.e., the interpretation of the test results). The technical component (i.e., the equipment costs, technicians, etc.) was not studied by the Harvard University researchers who developed the relative values.

We want to gather data to allow payment rates for radiology and diagnostic tests to be based on the resources required to produce a test efficiently.

**CONCLUSION**

The three-part physician payment reform was designed to moderate the rate of increase in Medicare physician expenditures, create the "right" relative prices for physician services, and give beneficiaries financial protection. The new system provides significant financial protection for beneficiaries. And the fee schedule takes great strides toward correcting historical inequities in how Medicare pays for physicians services, both geographically and among different types of services.

The MVPS provides a national collective incentive for the medical

community to moderate the rate of growth in expenditures for physicians' services. However, it is a very limited tool, because it creates little incentive for individual physicians. We need to devote more analytical efforts to developing approaches that create more direct incentives for physicians.

In closing, I would like to comment on the status of publication of the proposed fee schedule. We hope to have the regulation on display at the Federal Register by the end of May. There are many issues involved in the proposed fee schedule and I look forward to working with you and physician groups as we move toward its implementation.

Thank you. I will be glad to answer any questions you may have.

**COMPONENTS OF FY 1992 MVPS RECOMMENDATION**

| Factor | Nonsurgery | Surgery | All Services |
|---|---|---|---|
| Inflation | 2.1 | 2.0 | 2.1 |
| Enrollment | 1.3 | 1.3 | 1.3 |
| Aging | 0.1 | 0.1 | 0.1 |
| Factors Other Than Inflation Enrollment and Aging | 3.7 | 3.7 | 3.7 |
| OBRA 1990 | -1.0 | -1.7 | -1.1 |
| Fee Schedule | 0.8 | -1.2 | 0.0 |
| **Total*** | **7.1** | **4.1** | **6.2** |

*The components were multiplied to achieve the recommended FY 1992 MVPS.

NOTE: Recommendation should be adjusted to account for changes in pricing and benefits resulting from legislation enacted this year, if any, affecting FY 1992 physician outlays.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you.

Doctor, on page 3 you indicate that 48 percent of the physicians signed participation agreements, and that 85 percent of the physician bills were paid on assignment in the period January through March. Am I to assume that the 52 percent who are not participating physicians only constitute 15 percent of the physician bills paid?

Ms. WILENSKY. No. What that indicates is that there are a great number of physicians who are effectively participating physicians. That is, in almost all or in some cases, perhaps even in all cases, they actually accept assignment. They do not charge above the Medicare amount, but they are not willing to classify themselves as participating.

They want to retain the ability to charge the amounts allowed by law above the Medicare payment. In fact, that relationship of almost 2-to-1 between the number of visits that are accepted on assignment and the number of participating physicians has existed for some time, so that although only now 48 percent of physicians are participating, basically 85 percent of all visits are accepted on assignment.

Mr. MCGRATH. You indicate that there is no evidence of a national problem of access to care for Medicare beneficiaries. As you say, almost half of the physicians are participating physicians. In your view, though, will fee reductions or limits in increases have an effect on this access?

Ms. WILENSKY. The short answer is I don't know, but we are going to watch. There is no indication as of now that in the aggregate, for the Nation as a whole, Medicare beneficiaries have had difficulty getting to see physicians. There are, of course, both reports of physicians who say they do not accept new Medicare patients, although it is hard to quantify how frequently that occurs, and there are some areas of rural America that have reported difficulties.

We are, as you know, making substantial changes in fees and we are also putting increased limits on balance billing. That does raise the possibility that what has not been a problem in the past could become a problem in the future. We are setting in place a number of monitoring measures to make sure we can document whether or not there is, in the future, a problem in access, but to date there is not one. We think it is prudent to be on the lookout in case one develops in the future.

Mr. MCGRATH. Do you have any evidence that physicians are taking steps to reduce their volume of services in response to the MVPS?

Ms. WILENSKY. In fact, the evidence is in the other direction. We missed the MVPS target increase in our first year out of the box.

There is no evidence to date that I am aware of that we are making much progress in this particular area.

Mr. MCGRATH. As a result of that, I hate to use the word "targets," but updates will be reduced in the future?

Ms. WILENSKY. That is correct. What we are doing basically is what we know how to do, which is to control expenditures by reducing prices.

Even though we all understand that expenditures are a function of both prices and volume, we have not, to date, been able to figure out how to go after volume, so we keep going after prices.

Mr. MCGRATH. Since you are recommending an update, what would the recommendation have been had the experience not been in the opposite direction of that?

Ms. WILENSKY. One and one-half points higher. It would have been 3.7 instead of the 2.2.

Mr. MCGRATH. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. The printed copy that I have of your statement is much more detailed than your oral statement. Do you have a printed copy that you can leave with me?

Ms. WILENSKY. I have a printed copy of my oral statement.

Mr. MOODY. Could you summarize what the key points are of your oral statement regarding what public policy choices we face right now?

Ms. WILENSKY. Well, I think the main point that I was trying to make is that when we develop the volume performance standard for each year, we take account of aging, the number of beneficiaries and enrollment, and a factor that looks at a combination of access technology and appropriateness of care. I think the various groups are pretty much in agreement about what the inflation index is, what the aging of the population, what the increase in enrollment is.

Then, as we did last year, we included a factor of 3.7 percent for the volume and intensity unexplained by inflation and aging of the population. It is roughly half of what we have observed historically, indicating that while we have difficulty measuring the precise contribution of technology or inappropriate utilization that there is a general consensus that what we have observed in the last decade is higher than we are willing to tolerate.

With regard to the——

Mr. MOODY. Can I just stop you there before you go to the next point?

Ms. WILENSKY. Yes.

Mr. MOODY. So you can measure sort of objective things like population and rates of inflation, population cohort. In a statistical sense, you say there is an error term that combines three items?

Ms. WILENSKY. It is the residual policy.

Mr. MOODY. It is a residual item. Can you disentangle those three? Is there any way econometrically to separate out those three pieces you mentioned?

Ms. WILENSKY. Let me share with you what it is one would like to do because of what we have observed from the past and what we might want to do for the future.

Mr. MOODY. Right. But looking back as to what has happened, can we separate out those various pieces?

Ms. WILENSKY. No.

Mr. MOODY. Cannot?

Ms. WILENSKY. The access impact, we think, is basically zero. There is no impact that we are aware of. So it is really a question of technology and inappropriate utilization.

As I think the last hearing made clear, we are still relatively early in our development of information about inappropriate utilization. If it is flatly inappropriate, the number is probably 10 or 11 percent. If it is inappropriate and questionable utilization, the number could be much higher.

Mr. MOODY. What is the minimum inappropriate figure, would you say?

Ms. WILENSKY. I think the number is 10 or 11 percent, based on the evidence I have seen. I have to admit that even that is still pretty preliminary.

Mr. MOODY. If you subtracted out that de minimis inappropriateness, what is left to ascribe to technology component?

Ms. WILENSKY. If you had inappropriateness as a negative rather than as a positive, then you have a technology factor of about 4 to 4.5 percent.

Mr. MOODY. 4.5 percent growth in utilization?

Ms. WILENSKY. As a result of technology.

Mr. MOODY. Now, are there any other independent studies that would give us that number?

Ms. WILENSKY. I am not aware of any studies that look at the impact of aggregate technology. What we have done here is to try to allow for a volume and intensity growth that seems appropriate, given our inability to measure the kind of policy factors of what we think reasonable.

What we have been observing historically is that when you account for all these factors of inflation and aging and enrollment, we have 7 percent growth.

Mr. MOODY. What percent factor?

Ms. WILENSKY. About 7 percent. That is just too high.

Mr. MOODY. We think we have ways of bringing it down now?

Ms. WILENSKY. Well, what we are really doing in the MVPS is saying that what we have had in the past is not something we are willing to tolerate in the future. We are using this MVPS as a desired goal for expenditures. It doesn't, as you are well aware, impact behavior for the individual physician.

It does feed into the fee update in the future year.

Mr. MOODY. And the incentive might not bite where it needs to bite, therefore?

Ms. WILENSKY. It doesn't have anything to do with individual behavior.

Mr. MOODY. You were about to make a second point. I interrupted you.

Ms. WILENSKY. There are two areas we are really covering here. One is the MVPS, the performance standard, and the other is the update for physician fees. They are, of course, related.

In this case, as Mr. McGrath had me point out, the update would have been 1.5 points higher had we not overshot the MVPS expenditure target in 1990. There is, of course, a relationship between what happens in a past year and what we allow for fee increases in a future year. As you have indicated, that doesn't give a strong incentive at the individual physician's behavior level, so the MVPS has not had, at least to date, an impact on changing behavior that we can observe.

Mr. MOODY. I think it is a fascinating econometric challenge for anyone trying to disentangle these obviously interrelated right-hand variables who are interacting with each other as you go along.

Ms. WILENSKY. The technology issue is one we struggle with for hospital updates as well, and the difficulty is that most of our empirical knowledge of technologies are on a technology-by-technology level. The costs, may go up in the aggregate even though at a unit level it saves money, because physicians do more of them, like angioplasties relative to bypass. They are much cheaper at a unit level. Whether it saves the system money depends on how many do and how many bypasses you ultimately end up having to do.

When I was at Project Hope, we were doing work on the cost of technology. In fact, I think they still work with ProPAC in trying to assess the impact of changes in technology on hospital services, and it is very difficult to quantify. They have done some work for HCFA along the same lines, and it has just been, at least to date, impossible to have a single method of looking in the aggregate at what technologies cost do because they have so many different impacts.

Mr. MCGRATH. Will the gentleman yield?

Mr. MOODY. Actually, I am done. Go ahead.

Mr. MCGRATH. Something just occurred to me. I am assuming that these increases that have occurred have occurred on the aggregate. Do you have any tables which would show that individual classifications at any one level have disproportionately increased as opposed to others?

Ms. WILENSKY. Well, there is some information that we have now. We are in the process of getting ourselves in a position to have a lot more information on what is going on through the common working file, which is now in place and will allow us to put together part A and part B services by an individual and to assess it. We know there have been some major procedures that grew, based on some research we have done, and in particular on bypass surgery, arthroplasty, disk surgery, and laser surgery. There was about a 20-percent growth for advanced imaging, sonography and emergency room visits. Some of the medical specialties had very large growth, like gastroenterology and cardiology. The highest growth was in pathology and ophthalmology among the physician specialties.

So we do have some ability to monitor what is going on now. As I have said, we are getting ourselves positioned so we will be able to have a much better sense about what is going on.

Mr. MCGRATH. How much of that could be attributed to the evolution in the operating of medicine as opposed to those who may be gouging the system?

Ms. WILENSKY. I don't think we are in a position to know that. I think one of the most promising, but unfortunately long-term, change will result from the work that is going on in outcomes effectiveness research where we try, at an individual procedure level, to get some sense about whether something is worthwhile medically and whether it is appropriate, whether it is questionable, or whether it is just flat out inappropriate.

We know the information is there. And we know it differs for procedures, and we in the Department, the Public Health Service, HCFA, a lot of the speciality groups and the academic health centers are trying to break this information down. That would give us a much better sense about whether or not we are spending money for procedures that just make no sense medically.

I think everybody would agree if we could figure out what those procedures are, we ought to stop paying for them. The problem is, in the absence of some good information, how do you get a handle on inappropriate utilization?

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Ms. Wilensky, would it be fair to say that you feel that the physician volume performance standards are working fairly well in restraining the increased cost of physician services?

Ms. WILENSKY. I think, frankly, it is too early to make very much of a pronouncement. We have only had one MVPS thus far, and we are only now using the implication of having overshot that 1 year in an MVPS for an update, so until we at least got through the cycle of linking an update in future fees to missing the performance standard in a past year, we ought to withhold a little bit of judgment.

I am concerned, as I think I made clear, that because the volume performance standard affects the fee increase for all physicians, it doesn't hold a tremendous incentive to change behavior for individual physicians, which is where behavior change needs to occur, but I think it is a little premature to say very much negative. I think it is a more direct attempt to link future fee updates to past behavior than we have ever tried in the past.

We ought to be slightly more patient.

Mr. DONNELLY. How many years do you think we would need?

Ms. WILENSKY. I would give it a couple. I am worried that it wouldn't be as effective as many of us might have hoped because it does not direct itself to individual behavior, but it is also possible as we progress with implementing physician payment reform and develop better data system, that we will be able, I believe, to look at alternative ways to configure the volume performance standard. We are, in fact, doing some research, and we will be reporting to Congress on the results of our ability to define volume performance standards in different ways geographically or by specialty.

Mr. DONNELLY. As you know, the Medicare trust funds spend billions of dollars reimbursing hospitals to train physicians through our payment system. Under present law, there is no payback mechanism from those physicians for the subsidy provided by the Medicare system for their training, is there?

Ms. WILENSKY. No, and not much of an attitude that reflects some sense of repayment obligation, either.

Mr. DONNELLY. Wouldn't it make some sense, since it is our responsibility to the taxpayer and the beneficiary to set some sort of mechanism where that subsidy could be recaptured?

Ms. WILENSKY. That or change the subsidy. I think it is certainly fair to say that while subsidies exist——

Mr. DONNELLY. Which can be from $40,000 per year per physician in a hospital to more than $120,000 per year.

Ms. WILENSKY. That, of course, is one of the problems.

Mr. DONNELLY. Directly taken from money that should be used for the treatment and care of elderly Medicare beneficiaries.

Ms. WILENSKY. I have had this discussion with the committee on various occasions, indicating a desire to try to reduce some of the subsidy levels because I do believe it is inappropriate to use trust fund money for that purpose.

Although I would not want to dismiss what you are suggesting as a policy direction, one of the difficulties is that the amount of subsidy, as you know, varies tremendously from institution to institution, and therefore what an individual owes would also be variable, although it would be possible to calculate.

Mr. DONNELLY. It would seem to me it would make good sense if in terms of public policy for the beneficiaries to recapture part of that subsidy because that is money that is being withheld on an annualized basis from either expanding services or providing broadened services for the 33 million Medicare beneficiaries.

Ms. WILENSKY. It is an idea we would be willing to look at if you would like us to.

Mr. DONNELLY. Let me just ask you one final question. If, in fact, the volume performance standards seem to work fairly well in the out years, at least in restraining some of these enormous increases in spending, would it make some sense to expand it to the rest of the part B program?

Ms. WILENSKY. I think we ought to look and see how it works, but we are taking the notion of fee schedules to other parts of part B, not as explicitly but in some form. If it does work successfully here, I think that is generally something we should consider.

Mr. DONNELLY. Here are some projected increases in part B services: durable medical equipment, 11 percent; clinical labs, 22 percent; dialysis, 12 percent; hospital outpatient care, 17 percent in the next fiscal year. That is where the largest increase of rate of growth in part B spending is taking place. The only mechanism we have used to this point is on an ad hoc catch-as-catch-can dollars to some providers catch-as-catch-can basis. Wouldn't it make some sense to put some sort of total volume performance standard for all of part B?

Ms. WILENSKY. I think you may want to do it by category because, again, we develop some expectations about a reasonable expenditure that may well differ according to what category of service you are looking at. I am not sure exactly how some of the specific fee increases have been derived with regard to the other areas of part B.

We might want to include, as we do, in part, for the physician fee update, a relationship between a performance standard and actual expenditures. I think the concept is certainly one that could be used in other areas.

As you know, we are doing a lot of changes in pricing of DME during this calendar year. That may or may not, in fact, prove sufficient in terms of controlling total expenditures. As I think everybody on this committee is well aware, looking at prices only doesn't necessarily impact total expenditures in the way that one might hope. So making that linkage between a performance standard and

all real expenditures is something that could be extended to other areas.

Mr. DONNELLY. This isn't a hearing on DME. That is another whole subject that, I hope, this committee will continue to pursue, most especially after the hearing that was held by Senator Sasser, by the Senate Budget Committee in regards to some things that are happening in that industry right now.

I thank you for your comment, and just make you aware that I filed legislation today that would expand a volume performance standard to all of part B.

I would appreciate it if you would have an opportunity to look at that. There are two beneficiaries of that. One is the trust fund, and secondarily and most importantly, are the out-of-pocket expenses of our beneficiaries who we are charged with protecting, so I appreciate it. I will be sending you off a copy of that.

Ms. WILENSKY. Fine. I would be glad to look at it.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. As I read the materials and we looked them over in the office and then listening to your testimony, I think it is a little hard to discern how MVPS has made a difference or will make a difference in the future. It seems to me that what we need most of all is to be realistic and not to overpromise or overanticipate the usefullness of a particular tool.

At the end of your testimony, you say MVPS is a very limited tool, because it creates little incentive for individual physicians. We need to devote more analytical efforts to developing approaches that create more direct incentives for physicians.

How has MVPS really mattered and why is it likely to be any more effective than the old system of deciding about how much we could spend and then cutting reimbursement, which we did across the board for a number of years? Is this a more rational way of doing the same thing or does it provide a rationalization? How is it likely—you say it isn't likely to matter very much.

Ms. WILENSKY. I was definitely trying not to raise expectations in an inappropriate way.

Mr. LEVIN. That is another way of saying it is a limited tool. It isn't going to make much of a difference.

Ms. WILENSKY. Right.

Mr. LEVIN. Well, maybe we ought to leave it at that. It isn't going to make much of a difference.

Ms. WILENSKY. Well, let me answer your question first by saying what it is I think we have been trying to do and then what I think we ought not to expect from the MVPS. We are implementing the relative value scale in order to try to get the relative prices right.

That is the main purpose of physician payment reform. There has been a sense widely held in the Congress among the general public that the differences in prices that we were paying under Medicare, under Blue Cross/Blue Shield, under other third-party reimbursement for procedures like endoscopy or appendectomy relative to what we were paying for other services like various office visits or other primary care didn't make any sense.

We paid much too much for some services relative to what we paid for other services, and likewise, the difference between urban

and rural payments were much greater than the cost-of-doing-business difference would justify.

What we have done, through this relative value scale, is to try to rationalize the differences in price, to get the relative prices right. When you do that, one of the things you get into is not only setting fees, but once you have set fees across the board, you also get into the business of having to update the fees. What we are trying to do is to link the update to the aging of the population and enrollment, and also to what expenditures were in a previous year versus what we had hoped they would be. So we are trying now, in a way we haven't done previously, to directly link the fee update to what happened in terms of expenditures, which is price times quantity. Now, the decision was made to use a somewhat loose link rather than a very tight link when the decision was made to go to a volume performance standard rather than, say, a flat target. The reason I have said I think it is a limited tool is because it doesn't do anything to affect the incentives of individual physicians.

Mr. LEVIN. What are the ways to more effectively figure out costs and what the reimbursement schedule should be?

Ms. WILENSKY. I don't think our problem is so much with the reimbursement schedule on a price basis.

Mr. LEVIN. I mean, the overall——

Ms. WILENSKY. The problem is we can't figure out what the volume ought to be, and we keep targeting our efforts on the price. In the conversation we had, you pointed out a New England Journal article that physicians who have imaging equipment use four or five times more images than physicians who don't, and that was a distressing finding.

That was one more indication that our problem appears to be volume as opposed to price, but we haven't figured out how to control volume.

Mr. LEVIN. Let me ask you then quickly if this is a very limited tool—you mention on page 5 of your testimony that you are restructuring the data system, et cetera. Are you working on any other data collection or improvements or anything else that will illuminate our way on other tools that aren't so limited?

Ms. WILENSKY. Well, we are working on a number of things. For one thing, we are making progress on the effectiveness initiative. While I think outcomes and effectiveness are sometimes oversold, the fact is I do think there will be some net savings and better medicine will be practiced, and we ought to pursue it.

I think everybody would agree if we could eliminate totally useless procedures, it is a win/win situation.

The second thing we are trying is to have the PRO's go to a better definition of appropriateness of care. The PRO's working with the carriers in terms of medical review audits, again, will focus on outcomes and patterns of care.

The third area has to do with one of my favorite projects, which is trying to get people more and more into coordinated care systems, where you start changing some of the incentives to provide services.

We have a proposal in this year's budget, and will be coming forward with some legislation on point-of-service entities, trying to put part A and part B services together, trying to have networks of

physicians headed by primary care workers, trying to encourage more HMO's, multigroup specialty practices to come together to change the incentives for overutilization when individuals have a lot of third party coverage and physicians are paid on a fee-for-service basis. We are trying to intervene in the current incentives which are of course, exacerbated by the problems with liability and malpractice.

You not only have both physicians and hospitals looking to do more, you have some real reason to try to protect yourself as a physician or hospital in doing more rather than less if you think you can't do it right. So, we really have set up a system where incentives push us all to do more, and it is not very surprising that it is hard to control expenditures when that happens.

Mr. LEVIN. Thank you very much, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I am just sitting here. Maybe in my mind it is too simple, but if the cost is made up of volume times the price——

Ms. WILENSKY. Expenditures are made up of volume times price.

Mr. MCDERMOTT. Yes. And you can't—you can control the price, you can set the price, but you can't control the volume, you have then two ways to control the volume, either we arbitrarily in the Government do it or we say to the medical practitioners, you do it, and it seems to me that the only way you get at that—at least up to this point—is with a single-payer system. I can't see how you can do anything but have the Government say, "here is *x* amount of money. You, the professionals, make the decision on the volume."

Ms. WILENSKY. Well, that is one way. It is not the only way.

Mr. MCDERMOTT. Tell me the other ways.

Ms. WILENSKY. I think what you want to do is to change the incentives present in the system. If you want to know absolutely how much you are going to spend on something, the best way is to say here is the pot of money, that is what we are going to spend and no more. You can do that through a single-payer system.

But that is not the only thing I think we want to do through health care. I think that we would like to encourage innovation and change, and respond to consumer preferences and other things.

I think that you can do that and also start to change some of the incentives with how we organize the delivery of health care. One of the reasons that I am so interested in trying to promote coordinated care systems like HMOs and particularly PPOs, networks of physicians headed by primary care physicians, is because there are people who have strong feelings about moving in and out of a coordinated care system on a service-by-service basis that a traditional HMO might not allow, but a point of service HMO, which are developing in a lot of places, would allow. So this would provide a little more flexibility.

When you have coordinated care organizations like that, you have very different incentives in place because you have some financial responsibilities in line with the organization, and you don't have a situation where there is only an incentive to do more.

Yes, a capped, single-payer system is one way to control expenditures, but trying to change incentives so you have forces working

in a helpful direction rather than only encouraging more is also a way to reduce spending.

Mr. MCDERMOTT. There is a global single-payer system versus a multiplicity of payers; that is, the global one gives the capitated rate to the system and says you decide inside your little system rather than a global system, you are going to do it in various increments.

Ms. WILENSKY. It allows for more variation, and it changes the incentives by putting financial responsibility at a level with the providers, with the people that are providing health care.

So that some of the decisionmaking about whether to take care of somebody in the hospital or in the home or in a physician's office can be made by the group of professionals taking care of the individuals.

We try to micromanage that through Medicare.

In the end, we don't do a very good job of controlling costs, no matter how hard we try and how much we think we are doing this year relative to last year.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Russo.

Mr. RUSSO. Thank you, Mr. Chairman.

One of the questions I have concerns your recommendation for rate of growth. You have 6.2 percent, and the PPRC has 8.6.

Dr. Lee's testimony shows that the only difference between the recommendations is in the category stating "other."

Everyone agrees on inflation, on enrollment, on aging, and on the savings over 90, but there is one category called "other."

The PPRC has 6.2, and you have 3.7.

Would you explain the difference?

Ms. WILENSKY. I will say that we go about doing this differently, but that is where we differ in terms of——

Mr. RUSSO. It amounts to $500 million difference in money; is that right?

Per year, $500 million; is that what it is?

Ms. WILENSKY. That is about the order of magnitude.

What we were doing in developing the MVPS is looking at all the factors that account for expenditure increases, including the residual category that basically represents a policy decision about how much you think physician expenditures ought to grow.

We take account of inflation, of the number of new enrollees, of the fact they are aging.

Mr. RUSSO. What is "other?"

Ms. WILENSKY. That includes a combination of the effects of new technology, any concern about the need to increase expenditure levels for access, and inappropriate utilization, which is probably a negative factor.

What we observe historically over the past 6 years is that the "other" category has grown at a rate of 7.4 percent.

My sense is that most people that are sitting up there with you have stated over a good part of the last decade that physician expenditures and part B expenditures have grown too quickly and that we need to do things to reduce them.

We have said that we want to reduce the part that isn't accounted for by aging and population by half.

It was 7.4.

We want it to be 3.7.

Mr. RUSSO. You arbitrarily said 3.7?

Ms. WILENSKY. We could have said zero because we think expenditures have been growing too fast.

We don't have a way to calculate the amounts we would like to allow for technology.

If we could, we would specifically estimate the effects of new technology and how much we would like to have in the system from new technology, but we don't know how to do that.

Mr. RUSSO. My single-payer legislation uses expenditure targets to contain costs.

It seems to me that if you make them pay for going over the target, then you can effectively contain costs.

Ms. WILENSKY. We are trying to have a generalized effect from going over the target.

Because of the fact that for fiscal year 1990, expenditures were 1½ points higher than we had hoped for in our volume performance standard.

Consequently, the update we are recommending for 1992 is 1½ points lower than it would have been.

We end up chasing prices when we know it is volume and intensity that is causing the problem, but we haven't figured out how to control volume and intensity, so we are going after the part we know how to control.

Mr. RUSSO. Thank you, Mr. Chairman.

Chairman STARK. Gail, thank you very much for your testimony.

A couple of things that I think are missing, and I think perhaps are troublesome: Your analysis really gives us very little detail to the differences saved between growth in surgical and nonsurgical services, and growth in volume of emergency visits, no numbers.

We are in the third quarter of 1991 and still haven't received the first quarter report on growth and expenditures for the second cycle.

We have intermediaries throughout the country each of which has a different billing system on their computers.

Your own inspector general has suggested that it would be time that we had a single billing form and a single billing procedure.

When do you suppose that you are going to trade in your slide rules at HCFA and get into, at least the 20th century format on data processing and mandating some kind of reporting system so you have data?

We have talked about this, but there are no numbers here and that is because you don't either have prime or the computer programs to calculate it.

If you don't take the lead, you know the intermediaries won't because the more they can confuse the issue, the more they can charge you for lack of information.

When will we receive information backed by HCFA, which means Government regulation?

Ms. WILENSKY. Two pieces.

The first has to do with the common working file and the second with an activity we call contractor reform.

With regard to the common working file, this has been an activity HCFA has devoted a lot of time to—it is now fully phased in—of putting together information that comes in from different sources.

Chairman STARK. Why do you let it come in in different ways?

Ms. WILENSKY. That has to do with the second piece, contractor reform.

There are a lot of things we can or cannot do that are legislatively driven.

We are looking at the issue of contractor reform.

Chairman STARK. Would you like legislation to mandate universal reform?

I am champing at the bit. It doesn't cost anything, why don't we have uniform reporting? Is there a logical, philosophical, or academic reason not to have uniform reporting?

Ms. WILENSKY. We are looking at the whole issue of developing the kinds of software to use for uniform reporting.

This is something that we are looking into.

Chairman STARK. All you have to do is have the report, the uniform bill form, then the software comes. You don't know what report you want. Once you have the report, the software is a slam dunk. I can write it and if I can write it, anybody can write it. All we need is a report. This is how you are going to require people to report data. Can you imagine what the IRS would be like if we let each State use their own tax forms?

That is what you are doing.

Ms. WILENSKY. I don't want to try to defend some of the differences that go on in the Medicare system.

We have been spending a lot of time over the last 7 or 8 months on trying to understand how Medicare would be administered——

Chairman STARK. You have different data systems on Social Security under Medicaid and Medicare. Even in your own department the computer systems can't talk to each other.

Ms. WILENSKY. We are working on this issue. We agree there are a lot more differences out there than there should be. We have found a way to resolve what we need to do for physician payment reform through the common working file.

We are aware of some of the implications of all the differences, the number of intermediaries and carriers that now exist, and are analyzing that.

It will take time and money and some legislation to do that.

Chairman STARK. I understand that you have announced changes in how PRO's operate.

Would you classify those changes in nature as deregulation?

Ms. WILENSKY. I had never thought about it that way.

Chairman STARK. Oh, go on.

Ms. WILENSKY. I hadn't thought about whether or not it is more or less regulatory.

I am not against all regulation. How could I be?

I am the chief regulator in the country.

Chairman STARK. How can Dr. Billig be practicing medicine at some doc-in-the-box clinic in Delaware after he did time for a felony? I think it was manslaughter. He got it reversed on appeal, but the appeal didn't have much to do with—he didn't bring all

those guys back to life he chopped up. This guy is out there practicing medicine.

I don't know. The doctors tell you what a great job they do policing themselves, yet you have this guy running around. I think we should notify people. If you have warnings on the cigarette labels, you should put warnings on the clinic where Billig works. There is something wrong with a system that allows him to ply his trade out there. I hope that you are going to toughen up on the PRO issue rather than make it just more smoozey.

Ms. WILENSKY. We aren't accused of being smoozey most of the time——

Chairman STARK. What are you doing to get them to work on the volume issue?

What do you have in the works to say how are we going to lower this volume issue?

Ms. WILENSKY. One of the things that we are doing, particularly with the PRO's has to do with outcomes appropriateness and effectiveness.

We are trying to move PRO's away from a record-by-record, after-the-fact review to analysis of outcomes and patterns of care.

Chairman STARK. We heard testimony that outcomes research is not going to cut volume.

It will be interesting for physicians to know about it, but they are not going to do fewer proctoscopic examinations or take fewer x rays because of outcomes research, and that is the kind of nickel and dimeing that runs volume.

Outcome research will be very interesting if your doctor sits down and says, "Gail, I think you should have a bypass or valve repair."

You say, "How many people live?"

They will say, "We find that while 50 percent survive, that only in 30 percent does it extend their life much longer."

You say, "I want it anyway."

The doctor says, "Fine, because I want to sell you one anyway."

You know that we aren't going to limit it——

Ms. WILENSKY. I am not interested in overselling the savings potential of outcomes research, but it will provide more specificity if I have a certain amount of heart disfunction, if I have had various kinds of medical therapies, if I have other physical symptoms to indicate bypass surgery will have some effect. There may be cases where, if you have somebody with a certain set of symptoms, that there is no indication that surgery will help at all, and I assume we won't pay under those circumstances.

I think it is really inappropriate to perform a procedure that is proven ineffective.

Chairman STARK. Can you imagine in this country on either side of the aisle our passing any law that would deny somebody technical treatment?

Ms. WILENSKY. See, the point is that if you look at this as going after only the cases where there are no medical benefits or the procedure is totally inappropriate, I don't think that you need to pass any legislation.

Chairman STARK. How much do you spend in the last 30 days of life for 90-year-old people?

You know, they are going to die in a month. How much do we spend in those last 30 days?

Sure, we do.

Do you think that we are going to pass any laws saying pull the plug on grandma?

You know, we won't.

This country doesn't work that way.

The doctors may have to be the ones to counsel and say, "Gee, I don't think this is going to do much and we can medicate people and reduce the pain, but why do all these wires and tubes and stuff?"

I don't believe, as much as I agree with you, that we waste a lot of money in that area, but don't ask me to be so brave as to write a law that is going to deny——

Ms. WILENSKY. We do things in cases because we don't know there is no medical benefit associated with it.

Chairman STARK. We don't have a rule that says we don't pay.

Ms. WILENSKY. That is a different issue.

Chairman STARK. If you honestly think that we would ever pass a law that says deny this, I don't care what it is—dialysis is a good example.

Are we going to say no dialysis after age 80?

Ms. WILENSKY. No, because you won't be able to make a decision like that based on medical appropriateness.

When we can identify that there are medical procedures that have no use whatsoever, we don't cover them.

I think we are trying to identify such procedures with outcomes research. We challenge procedures now through our medical review and where we think they are completely inappropriate.

Chairman STARK. I bet we could go through cataract records and find a lot of procedures that were of questionable or little value but we paid for it.

Ms. WILENSKY. I think we will use outcomes research for payment purposes in those areas where there are no appropriate medical outcomes, and I don't think there is a huge number, but I think it is positive.

Chairman STARK. I don't think you are going to find zero.

You may approach it and say it is a marginal benefit, but I don't think there will be a place where you can say none.

Before we hang our hat on the fact that we are going to do this research in outcomes, which I think will be useful—I don't think it will save 10 cents and I don't think you will get us to move on it—to go off in that advocacy programs for insuring all Americans.

It is hard to be against it, but you will not get it.

Mrs. Johnson.

We have a vote and the first bell has rung.

Mrs. JOHNSON. I will be very brief so we will be able to break.

I assume, Dr. Wilensky, that what you were referring to earlier was the comparative performance report programs in talking about using guidelines to control volume?

Ms. WILENSKY. Right.

Mrs. JOHNSON. I think I can address most of my questions to the speakers on the other panels. But, regarding the conversation that was just entered into between you and the chairman, frankly, I

think if we can't control volume through disseminating information about what works and what doesn't work and what is necessary and what isn't necessary, then we will have to control volume through arbitrary caps.

The testimony on managed care demonstrated that you could control volume through some kinds of enlightenment rather than through arbitrary action.

I hear what you are saying, that we wouldn't exercise that right to not reimburse except where outcomes were very clear. However, I think there are many patients that if they knew the odds of efficacy would make very different choices than they are making today, even for those last months of life that are so expensive.

Ms. WILENSKY. There are two areas other than the absolutely inappropriate.

Part of what I hope will happen is that it is not only the physicians that have access to this information, but the patients as well, so that they have some sense of whether or not the procedure they are about to undertake is likely to work.

I think it has potential for affecting liability in an important way so you don't always have to do more in order to protect yourself from being sued.

How to control volume is to change the incentives facing physicians.

One of the reasons I am in favor of coordinated care is that it does change the financial incentives of providers since you have a group at financial risk in terms of the services provided and they don't have incentive to do more than necessary.

The way to decrease the volume of spending is by concentrating on outcomes effectiveness, getting the information disseminated, and trying to change the financial incentives particularly for those providing services, as through managed care.

Chairman STARK. I am going to recognize Mr. Donnelly for a graphic presentation for 30 seconds.

Mr. DONNELLY. Mr. Russo and I would like to point out that the Canadian health system is 13 pages, which is written in English and French, and covers every Canadian citizen all their lives—13 pages as opposed to this 600 pages called the Medicare system, just the enacting legislation.

I think the visual is pretty clear what is wrong with our system, it is too complex and cumbersome.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

I want to follow up on two things. I want to comment on the intemperate remarks of the chairman regarding Dr. Billig.

I don't know Dr. Billig, but if Dr. Billig were in New York State, the New York Education Department that licenses him and the health department probably would have something to say about it. I think the statement fairly assumes that doctors tolerate in their own profession people who are not capable, and I don't think that is true at all.

Second, let me just ask as an aside, I am having a terrible problem at home between intermediaries and your Department regarding who is a primary payer under Medicare. Those beneficiaries who are clearly not working and are covered by Medicare are

having their medical claims denied. Some of those people were at one time working after they were on Medicare, but are no longer employed.

Something happened in the computer.

The glitch has gone on for a year now.

I wish somebody in the Department would look at this to find out who is eligible.

I understand they are going on a case-by-case, claim-by-claim basis. I think it would be more cost beneficial to assume that Medicare is the primary payer as long as the beneficiary says so, and if not maybe to make recompense some way in the future.

People are not being paid on legitimate claims from Medicare for months and months.

Ms. WILENSKY. We will be much better able to figure out whether Medicare is a primary payer or a secondary payer as we get the data merged among IRS, Social Security, and Medicare.

We are criticized when we have Medicare paying as a primary care payer where the statute would suggest that Medicare is the secondary payer.

Many of your colleagues take us to task for spending Medicare money inappropriately when we do that.

We need a way to make sure people do not get penalized because of our data inadequacies.

Chairman STARK. Thank you very much.

We will recess for 10 minutes at which time we will hear from the gentleman from Pittsburgh.

[Brief recess.]

Chairman STARK. The committee will resume.

Our next witness is Dr. Phil Lee of the Physician Payment Review Commission; accompanied by Dr. Ginsburg.

Phil, welcome back.

It is a pleasure to see you, as usual.

## STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. LEE. Thank you, Mr. Chairman.

I will submit my testimony for the record and comment.

I will do it page by page to simplify it.

I would like to say at the outset that in addition to our comments on the fee update and the volume performance standard, we are required by OBRA 1989 to comment on the Secretary's annual report on utilization, access, and quality of care.

While we planned to have a single report dealing with all of these, the Secretary's report on access was released too late to be considered for inclusion in our report. We will consult with our Advisory Panel on Access and forward our comments to you by July 1.

A word about the volume performance standard.

I think there was some confusion in the earlier dialog on this.

The volume performance standard really has two roles.

One is a budget tool where increases or decreases in expenditure growth will generate offsetting changes in fee updates. We believe

that the volume performance standard gives Congress a structured process for stabilizing the growth of part B outlays.

We believe it will take 2 or 3 years for it to fully demonstrate that effect, but that is clearly one of the roles of the volume performance standard.

The second is an incentive mechanism for physicians.

It potentially creates motivation for collective action by physician organizations as now written.

Physicians will be rewarded with higher fees if education, practice guidelines, and payer review are effective in reducing the overall growth in volume and intensity of services.

If in the future it appears that specialty targets, for example, for cardiology or gastroenterology or ophthalmology, appear to be particularly feasible, then you would have a much more refined tool for influencing individual physicians or specialists.

At the moment that tool is not very refined.

As you know, on April 15 of each year, the Secretary of HHS must make recommendations on the fee update for the coming calendar year and a VPS rate of increase for the coming fiscal year. The Commission must comment on the Secretary's recommendations and make its own recommendations by May 15. We have submitted our report.

Three different fee updates must be established: One for all services; one for surgical services; and one for nonsurgical services.

This year, the Secretary recommended a single fee update of 2.2 percent for all categories of service. The Commission similarly recommends a 2.2 percent fee update to be applied to all categories of service.

Similarly, three performance standards must be established: One for all physician services, one for surgical services, and one for nonsurgical services.

I think the important point here is the basis for the decisions by the Secretary and by the Commission.

As Dr. Wilensky indicated, the Department's recommendations really are based on a judgment regarding an arbitrary reduction in the rate of increase of expenditures.

Last year, the Commission stated a guiding principle that the rate of growth of Medicare physician service outlays be brought down to some sustainable level such as the trend rate of growth in gross national product.

Because growth in the volume of physician services has typically exceeded GNP growth by 4 to 5 percentage points, the Commission recommended a strategy of gradually reducing the VPS rate of increase until it is 4 to 5 percentage points below the expenditure growth baseline.

This year, our recommendations are consistent with that principle. We would assume that over the next 3 or 4 years, until 1996, we will incrementally recommend reductions following that principle.

To gauge the appropriate amount of reduction, the Commission reviews data on outlay and volume growth and information on access, appropriateness, and technology.

It attempts to estimate the reduction in volume growth that is warranted by these factors.

At the same time, when considering the feasibility of its recommendations, the Commission considers the magnitude of the reduction and the availability of tools for constraining volume growth.

This approach is based on the assumption that a VPS that is impossible to achieve does little or nothing to motivate the medical community to seek ways to restrain volume growth.

Last year, the Commission started from the actuary's baseline expenditure projection and reduced it by a factor of 2 percentage points to arrive at its VPS recommendation.

This year, the Commission once again started from the actuary's expenditure projection, but reduced it by a factor of 2.5 percentage points to arrive at the VPS recommendation.

Thus, the Commission's recommendation this year continues the policy developed last year, moving about halfway toward a 1996 goal to a 4 to 5 percentage point reduction in expenditure growth.

In the testimony, Mr. Chairman, we discuss the tools for controlling the volume of Medicare physician services. Those were discussed at some length with Dr. Wilensky, and I won't elaborate on what we said in the testimony. However, we think that profiling may become an important tool in this regard.

Also, I would make a note with respect to outcomes research. In our report we noted that the rate of use of transuretheral prostatectomies decreased. I think that decrease is partially a result of the widespread dissemination of the results of Dr. Winburg and his colleagues' work on transurethral prosthetic surgery and outcomes of that research.

So there are areas where that information may have a significant influence on volume through an educational process, although I wouldn't count on that as a major tool. In some areas, it seems to be effective.

With this first complete set of volume performance standards and fee update recommendations, the volume performance system has become fully operational.

True to the original intent of the policy, both the Commission and the Secretary based their recommendations for the 1992 fee update on the difference between 1990 expenditure growth and the volume performance standard.

If the Congress accepts these recommendations, it will have set a precedent for the envisioned linkage between volume growth and fee growth. We think that is a very important principle.

The Commission has recommended remaining on a path of moderate but increasing reductions in growth in outlays and volume. That is the reason our VPS recommendations reflect a more modest reduction than the Secretary's.

We believe this will give the medical community both the incentives and the time to work to reduce volume growth.

The success of the volume performance system, however, depends on substantial progress being made to develop and implement tools such as profiling, effectiveness and outcomes research, and practice guidelines.

The Commission's recommendations afford the greatest incentive and opportunity for the medical community to move these efforts forward and to commit itself to more orderly and systematic approaches to determining the appropriate volume of care.

Thank you, Mr. Chairman.
Chairman STARK. Thank you, Phil.
[The prepared statement follows:]

## STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today on behalf of the Physician Payment Review Commission to discuss the Commission's recommendations regarding the fee update for Medicare physicians' services for the coming calendar year and the Medicare Volume Performance Standard (VPS) rate of increase for fiscal year 1992. I will also comment on the status of tools that can be used by physicians to control growth in the volume of services.

OBRA89 also requires the Commission to comment on the Secretary's annual report on utilization, access, and quality of care. While the Commission had planned to produce a single report to the Congress commenting on both of the Secretary's reports, the access report was released too late to be considered for inclusion in the Commission's May 15 comments concerning the VPS. The Commission will consult with its Advisory Panel on Access and forward comments on this report to the Congress in July.[1]

### BACKGROUND

The Medicare Volume Performance Standard was designed to help slow the increases in outlays for physicians' services by setting a target for growth. This target rate of growth is to be compared to the actual rate of growth of expenditures in determining annual fee updates. Lower expenditure growth may lead to higher fee updates, and vice-versa.

The VPS serves two roles in determining outlay growth. First, it is a budgeting tool. Sharp increases or decreases in expenditure growth will generate offsetting changes in fee updates. Hence, the VPS gives the Congress a structured process for stabilizing the growth in Part B outlays. Second, the VPS is an incentive mechanism. It creates a financial motivation for action by physician organizations. Physicians will be rewarded with higher fee levels if education, practice guidelines, and peer review are effective in reducing the overall growth in volume and intensity of services.

### RECOMMENDATIONS

On April 15 of each year the Secretary of Health and Human Services must make recommendations on the fee update for the coming calendar year and a VPS rate of increase for the coming fiscal year. The Commission must comment on the Secretary's recommendations and make its own recommendations by May 15.

Three different fee updates must be established: one for all services, one for surgical services,[2] and one for nonsurgical services. This year, the Secretary recommended a single fee update of 2.2 percent for all categories of service. The Commission similarly recommends a 2.2 percent fee update to be applied to all categories of service (Table 1).

Similarly, three performance standards must be established: one for all physician services, one for surgical services, and one for nonsurgical services. For FY 1992, the Secretary recommended rates of increase of 6.2 percent for all physician services, and 4.1 percent and 7.1 percent for surgical and nonsurgical services, respectively. The Commission recommends rates of increase of 8.6 percent for all physician services, and 6.6 and 9.6 for surgical and nonsurgical services, respectively (Table 1).

#### Fee Update

The Omnibus Budget Reconciliation Act of 1989 (OBRA89) specifies that the fee update recommendation is to take into account the percentage change in the Medicare Economic Index

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[1] OBRA89 also requires that the Commission comment on a HCFA report on allowing groups of physicians to "carve out" their own group-specific VPSs. While the Commission examined carve-outs in its 1990 report and rejected them as unworkable, it will offer further formal comments on this issue when the Secretary's report is released.

[2] Surgical services are defined by the Secretary as all services classified as "surgery" in the Medicare claims reporting system that are performed by surgeons, plus all assistance at surgery.

(MEI) and then adjust for the difference between last year's expenditure growth and the corresponding VPS target.

As I mentioned previously, the Secretary recommended a 2.2 percent fee increase for all physician services for calendar year 1992. This recommendation follows the default fee update formula, reducing the MEI by the amount that expenditure growth exceeded last year's VPS. The Secretary took the projected 3.7 percent increase in the MEI,[3] and reduced it by 1.5 percentage points (the difference between FY 1990 expenditure growth of 10.6 percent and the FY 1990 VPS of 9.1 percent) to arrive at a recommended update of 2.2 percent.

The Secretary's recommended fee update applies to both surgical and nonsurgical services. The decision to recommend a single update was made for two reasons. First, the 1990 VPS rate of increase was not broken into separate surgical and nonsurgical components. And second, the data processing system in place in 1990 did not allow an accurate determination of the separate rates of growth for these two categories of service.

The Commission also recommends a 2.2 percent fee increase for all physicians' services for calendar year 1992, following the default update formula. Like the Secretary, the Commission recommends that the same update be applied to surgical and nonsurgical services.

**Volume Performance Standard Rate of Increase**

Under OBRA89, recommendations regarding the VPS rate of increase are to consider several factors including inflation, growth and aging of the beneficiary population, evidence of lack of access to care, evidence of inappropriate utilization, changes in technology, and any other factors as appropriate.

For the FY 1992 VPS, the Secretary recommended a rate of increase of 6.2 percent for all physician services, and 4.1 percent and 7.1 percent for surgical and nonsurgical services, respectively. The Secretary made full allowances for expenditure growth due to increases in fees, growth and aging of the beneficiary population, and the effects of prior legislation. The Secretary also allowed 3.7 percentage points for increases in volume and intensity per beneficiary, half the recent trend.

This recommendation reflects the fact while inflation and beneficiary growth and aging are fairly easy to measure, the three other factors--access, appropriateness and technology--have proved difficult to quantify. The Secretary noted that research currently being funded by the Health Care Financing Administration (HCFA) will help improve our understanding of the effects of these factors on expenditure growth. After determining that the impact of access, appropriateness and technology could not be accurately assessed, the Secretary made his volume recommendation by allowing half the recent trend in volume and intensity growth per beneficiary.

At its May meeting, the Commission examined the Secretary's recommendations and rationale. After reviewing the available evidence, the Commission then recommended a higher VPS rate of increase based on somewhat different reasoning.

Last year, the Commission stated a guiding principle that the rate of growth of Medicare physician services outlays be brought down to some sustainable level, such as the trend rate of growth in Gross National Product (GNP). Because growth in the volume of physicians' services has typically exceeded GNP growth by 4 to 5 percentage points, the Commission recommended a strategy of gradually reducing the VPS rate of increase until it is 4 to 5 percentage points below the expenditure growth baseline.

Guided by this principle, the Commission's annual VPS recommendation is based on judgment of an appropriate and feasible reduction from the expenditure growth baseline. To gauge the appropriate amount of reduction, the Commission reviews data on outlay and volume growth and information on access, appropriateness, and technology. It attempts to estimate the reduction in volume growth that is warranted by these factors. At the same time, when considering the feasibility of its recommendations, the Commission considers the magnitude of the reduction and the availability of tools for constraining volume growth. This approach is based on the assumption that a VPS that is impossible to achieve does little or nothing to motivate the medical community to seek ways to restrain volume growth.

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[3] This projection included the 0.4 percent reduction specified in OBRA90.

Last year, the Commission started from the Actuary's baseline expenditure projection and reduced it by a factor of 2 percentage points to arrive at its VPS recommendation. This year, the Commission once again started from the Actuary's expenditure projection but reduced it by a factor of 2.5 percentage points to arrive at the VPS recommendation. Thus, the Commission's recommendation this year continues the policy developed last year, moving about half-way toward a 1996 goal of a 4 to 5 percentage point reduction in expenditure growth.

To develop its numerical VPS recommendation the Commission began with the Medicare Actuary's baseline projection of 11.2 percent growth in physician services outlays for FY 1992.[4] This includes a projected 8.6 percent increase in volume of services per beneficiary. After reviewing the evidence on appropriateness, access, and technology, the Commission decided that physicians could feasibly achieve a 2.5 percentage point reduction from that baseline volume growth. This yielded the Commission's VPS recommendation of 8.6 percent. In essence, this recommendation allows for a 6.1 percent increase in volume and intensity of services per beneficiary in FY 1992.

The Commission's recommended rate of increase (8.6 percent) differs from the Secretary's recommendation (6.2 percent) in two respects. First, while the Secretary used the historical rate of growth of volume to determine a baseline expenditure growth of 10.0 percent, the Commission used the Actuary's projection of volume growth in its expenditure baseline of 11.2 percent. Second, the Secretary reduced this baseline volume growth by 3.7 percentage points, or half the historical trend, while the Commission determined that a 2.5 percentage point reduction was consistent with its long-term goals. The combination of a higher baseline (11.2 versus 10.0) and a smaller reduction from baseline (2.5 versus 3.7) led the Commission to recommend a VPS that was 2.4 percentage points higher than the Secretary's. The Commission and the Secretary used the same estimates for the impact of growth and aging of the beneficiary population, inflation, and legislation.

OBRA89 called for the Secretary and the Commission to recommend a separate VPS for surgical and nonsurgical services. The Secretary recommended VPS rates of increase of 4.1 and 7.1 percent for surgical and nonsurgical services, respectively. The Commission recommends VPS rates of increase of 6.6 and 9.6 percent for surgical and nonsurgical services, respectively. For both recommendations, the difference between the surgical and nonsurgical standards is accounted for entirely by the differential effects of law and regulation.

As it did last year, the Commission recommends that the VPS recommendations be amended for most but not all future changes in legislation. This reflects the Commission's view that the VPS should not be reduced where legislation directly seeks to reduce the volume of services or utilization. Legislation that eliminates payment for specific services, such as OBRA90 provisions affecting payment for certain assistance at surgery services, should not lower the VPS. Instead, all reductions in the volume of services paid for, whether initiated by physicians or by legislation, should count as reductions in volume that help meet the VPS target.

On the other hand, it is appropriate to reduce the VPS if changes in law or regulation result in fee reductions. The Commission further recommends that both recommendations be adjusted if the Medicare Actuary revises the projection of the 1992 increase in the MEI.

## TOOLS FOR CONTROLLING THE VOLUME OF MEDICARE PHYSICIAN SERVICES

The success of the VPS system in controlling Medicare expenditure growth depends on the ability of physicians to act collectively to constrain volume growth in Medicare services. To do this, physicians need tools that will help them work together to slow growth, reduce the volume of inappropriate care, and practice a more efficient and effective style of medicine. A number of these tools, including effectiveness and outcomes research, practice guidelines, and profiling physicians' practice patterns are discussed here. While these efforts will not be fully operational for several years, the Commission believes they hold great potential in slowing growth.

### Effectiveness Research and Practice Guidelines

While the VPS mechanism gives physicians a collective incentive to decrease the amount of inappropriate care delivered, physicians frequently cannot identify when services are unnecessary

[4] The baseline refers to the expenditures expected to occur in FY 1992 with no further changes in legislation and no additional action by physicians to control costs.

or inappropriate. Effectiveness research and practice guidelines are a critical element in any strategy to improve clinical practice and slow volume growth.

The Commission recommended expanded federal commitments to such efforts in its 1989 report and continues to support appropriate funding for the Agency for Health Care Policy and Research (AHCPR). Now that AHCPR's work is well underway and publication of its first practice guidelines--those related to management of urinary incontinence, benign prostatic hypertrophy, and post-operative pain--is expected later this year, the Commission intends to take a closer look at the Agency's progress as well as its plans and priorities for the future. As part of this inquiry, the Commission plans to consider whether the development of practice guidelines is being in focused in areas where there is substantial potential to reduce inappropriate services.

There are also many private initiatives to improve knowledge of treatment outcomes and to develop practice guidelines. These efforts are being sponsored by the American Medical Association, medical specialty societies, insurers and nonprofit organizations. The Commission plans to assess the degree of progress that these initiatives are achieving.

Several issues must be addressed before effectiveness and appropriateness research have their desired effects on the practice of medicine. For example, patient preferences should be incorporated into practice guidelines, and methods for developing, assessing, and disseminating practice guidelines need to be improved. To be successful, practice guidelines must be accepted by physicians and used by them to change their practices. The AHCPR is developing a research agenda to investigate these issues.

The effect of practice guidelines on volume and expenditures, even when appropriately developed and disseminated, however, remains unknown. While substantial reductions in the provision of unnecessary care could be made, it is also possible that beneficial services are underutilized to a comparable extent. In addition, as new services are developed and proven effective, more services may be delivered, leading to increased expenditures. This raises questions as to whether the criterion of cost-effectiveness should be incorporated into practice guidelines.

**Profiling**

Physician practice profiling is a promising technique that is widely applicable to utilization review, cost containment, quality assurance, and effectiveness research. Profiling can contribute to the success of the VPS system by helping physicians and payers understand changes in patterns of care and by pinpointing areas where practice guidelines are needed.

By shifting the focus of assessment from individual services to patterns of care derived from many services, profiling can also allow utilization review to be more efficient and less intrusive for practitioners. This tool can be particularly useful for assessing utilization of outpatient services, which tend to be low in unit cost and high in volume.

Several issues must be addressed before profiling can realize its full potential for controlling volume. Medicare claims data should be made more accurate and standardized across carriers. This process is already being facilitated by introduction of the Common Working File and the Medicare Fee Schedule. HCFA is also improving specialty designation in its files to include more specialties. To be most useful, claims data must be adjusted for case mix, severity of illness, and co-morbidities. The Uniform Clinical Data Set may help meet these needs for inpatient care.

Other factors affecting the ability of profiling to control volume include the nature and timeliness of feedback, the ability of practitioners to interpret the results and improve their practices, and access to information concerning profiling. The Commission will be looking at these issues over the coming year, and intends to hold a conference to learn more. AHCPR also has plans to fund studies that will help inform how best to disseminate and implement profiling results.

Medicare's new Comparative Performance Report Program uses profiling to inform physicians when their practice patterns differ significantly from that of their peers. While the program will not likely have a substantial effect on volume this year, it can serve as a beginning to more sophisticated uses of profiling in utilization review.

### Other Factors

There are many other factors affecting the growth in volume and expenditures under Medicare. The introduction and diffusion of new technologies may increase expenditures if they substitute for less expensive services or provide new opportunities for diagnosis and treatment. The supply of physicians and their degree of specialization are important determinants of the amount of services delivered. The role of the current medical liability system and the extent of defensive medicine are not yet completely understood. Fears about personal liability may prevent physicians from reducing the volume of certain services such as diagnostic procedures that may be provided primarily to reduce the threat of suit. Reform in the present system of malpractice may be needed to allow physicians to follow guidelines or parameters that suggest a less aggressive approach.

## CONCLUSION

With this first complete set of VPS and fee update recommendations, the VPS system has become fully operational. True to the original intent of the policy, both the Commission and the Secretary based their recommendations for the 1992 fee update on the difference between 1990 expenditure growth and the 1990 VPS. If the Congress accepts these recommendations, it will have set a precedent for the envisioned linkage between volume growth and fee growth.

The Commission's goal of reducing physician services expenditure growth to the level of growth of nominal GNP must be undertaken at a reasonable pace and must be tempered by the experience of the next few years. A VPS that is impossible to achieve will result in the maximum reductions to the fee update, eliminating any tradeoff between volume growth and fee growth and creating little incentive for action by the physician community to restrain volume growth.

In this light, the Commission has recommended remaining on a path of moderate but increasing reductions in outlay growth. This will give the medical community both the incentive and the time to work to reduce volume growth. The success of the VPS system, however, depends on substantial progress in efforts to develop and implement tools such as profiling, effectiveness and outcomes research, and practice guidelines. The Commission's recommendations afford the greatest incentive and opportunity for the medical community to move these efforts to forward and to commit itself to a more orderly and systematic approach to determining the appropriate volume of care.

**Table 1: Fee Update and Medicare Volume Performance Standard Recommendations: Physician Payment Review Commission versus Secretary of Health and Human Services**

| | Fee Update Recommendations for Calendar Year 1992 | |
|---|---|---|
| | Commission | Secretary |
| Medicare Economic Index | 4.1 | 4.1 |
| OBRA90 Reduction | -0.4 | -0.4 |
| 1990 VPS Less 1990 Expenditure Growth | -1.5 | -1.5 |
| Total (Fee Update Recommendation) | 2.2 | 2.2 |

| | Medicare Volume Performance Standard Recommendations for FY 1992 | | | | | |
|---|---|---|---|---|---|---|
| | Commission | | | Secretary | | |
| | All | Surgery | Nonsurgery | All | Surgery | Nonsurgery |
| Inflation | 2.1% | 2.0% | 2.1% | 2.1% | 2.0% | 2.1% |
| Enrollment | 1.3 | 1.3 | 1.3 | 1.3 | 1.3 | 1.3 |
| Aging | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| OBRA90 | -1.1 | -1.7 | -1.0 | -1.1 | -1.7 | -1.0 |
| Fee Schedule | 0.0 | -1.2 | 0.8 | 0.0 | -1.2 | 0.8 |
| Other | 6.1 | 6.1 | 6.1 | 3.7 | 3.7 | 3.7 |
| Total (VPS Recommendation) | 8.6 | 6.6 | 9.6 | 6.2 | 4.1 | 7.1 |

Notes: These recommendations should be revised if law or regulation change prior to FY 1992.

The VPS formula is multiplicative. Columns will not add exactly to totals.

The "Other" category is the allowance for growth in volume and intensity of services per beneficiary.

Chairman STARK. On tables 2 and 3, it appears that cardiology, gastroenterology, and pulmonary diseases show volume that grows more than 15 percent a year.

Now, is this just an accident of how we get sick or is there a direct correlation between the number of specialists in these fields and the number of procedures?

What can you draw from that?

Dr. LEE. I think you put your finger on both the problems.

One, there is new technology and there is an increasing number of specialists, particularly in cardiology and gastroenterology where the volume of services is increasing rapidly.

We also are experiencing a very large increase in the volume of physicians in general. In 1986, there were 144 physicians per 100,000 population—those are physicians in actual clinical practice.

That ratio will increase to about 176 per 1,000 by the year 2000, which is 90,000 more physicians than is necessary to maintain the current physician-to-population ratio.

So the overall number of physicians is increasing and there have been rapid increases in new technologies in the fields of cardiology and gastroenterology, which are being applied vigorously. The result is dramatic increases in volume in those fields.

If you look at table 2 in the report, you notice that the annual volume increase for one type of angioplasty is 30.6 percent and for another type 79.9 percent over the period 1986–89.

The volume of cardiac services increased 13.4 percent annually over this same period. Gastroenterology procedures, ultrasound, and endoscopies, are all areas where there are significant increases in volume in contrast to the primary care services of the family physician or the general internist. The volume of office and hospital visits has increased very, very little.

Chairman STARK. Part of that gets tied in with new technology. I am sure a lot of that may come in the area of surgery. But I tend to think of new technology and both independent lab services and radiology, diagnostic types of tests, as the biggest cause. With 20 percent growth in volume, that means it is going to double in about 3½ years, and it is now 7½ percent of the total outlays so it will be 15 percent of the outlays.

Then you have radiology outlays that are growing at 13 percent, so in 5 years, that ought to double. It is now 12 percent, so it will be 25 percent of everything we spend.

I guess my question is, Can we look at tests differently from procedures?

You know, it seems to me if you are my doctor and you say I ought to have a kidney transplant or I ought to have my gall bladder taken out, that is one issue where outcomes research can perhaps let me make a more informed decision and you will have better data on what good it will do me.

I only have one gall bladder, right?

Dr. LEE. We hope so.

Chairman STARK. Boy, they could x ray that gall bladder 15 ways from the deuce and I wonder whether we could separate the physicians that I know—actually, I don't believe—it seems to me physicians don't take x rays.

There is a subaltern in there who snaps the picture and the physician looks at it later, but they get a lot of dough for that.

It is like the guy with the dull needle who takes blood. That seems to be supervised by doctors, but not done by them.

Dr. LEE. I think we can look at surveys of various physician specialty groups and others for information on the impact of new technology on volume increases.

In any 1 year, new technology does not have a large impact. When the technologies are in place, they are no longer new, but they have a big impact on costs. The diagnostic technologies, I would guess, have a bigger impact on costs because many of them are relatively low-risk.

Chairman STARK. They are getting $700 and $800 for an MRI.

If you used one efficiently, there is probably no reason that you couldn't make a decent living doing them for $300 or $400.

It is just that you have a lot of them not used 8 hours a day, so they have to amortize the cost to keep the people who make these things happen.

If we just said $400 period, we could cut the cost of MRI's in half and I suspect that we would still get them done.

Dr. LEE. You have already done that with the overvalued procedure policies which have significantly reduced the prices of a number of those radiology diagnostic procedures, surgical procedures, and other diagnostic procedures.

But in terms of sheer volume, the problem is not surgeries. You can only do one cholecystectomy per person.

My dad had five kids who went to Stanford Medical School. He was asked how he could afford to have five kids at medical school.

He said chronic appendicitis; so it does happen.

The general surgeons increased their volume very little. It is the diagnostic procedures that increased more rapidly.

I think that we could do a more detailed analysis of the impact on volume and expenditures of those diagnostic procedures, separating them from those procedures that are surgical.

Chairman STARK. Somebody brought up the idea that we allow discounting to go on when doctors bill for diagnostic services.

We pay directly in Medicare so the labs bill the doctor at 50 percent of the price, the doctor bills it out, and we are talking about just making that against the law.

That is going to make some labs happy, some doctors very unhappy, but I think that those are some business practices—Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

I also would like to ask the same question I asked Dr. Wilensky.

Since we are on the subject of imaging, how much of this problem as we describe it is just a result of the evolution of technology and the way doctors do the business of medical care these days?

It would seem to me as a layman that if you had a better way of diagnosing a problem because of a CAT scan or an MRI, you-would prefer to use that over an x ray and you may save a few bucks in malpractice premiums also.

It seems to me that if this is the problem, why not just address that as the problem—the amortization of the cost of the technolo-

gy—rather than apply it to some general reimbursement for specific procedures done by that machine.

Dr. LEE. There are several things that can be done. One is the volume performance standard could be made more specialty specific.

It could deal with that perhaps more efficiently.

Another would be to have effective technology assessment before the technology became available.

HCFA suggested looking at new technologies not just from a safety and effectiveness standpoint, but from a cost-effectiveness standpoint, so that a technology gets approved if it is more cost-effective than existing technologies or if it is safer and more effective.

We have done a poor job on technology assessment.

We have done an excellent job on the evaluation of prescription drugs before we permit them to enter the market.

I think we suffer because we do not have a good system to effectively regulate the introduction of technology.

Mr. MCGRATH. Some of the providers in New York may disagree with the amount of regulation that is attendant to their profession, but I will say there is a dichotomy here between the regulation of these esoteric machines in hospitals and those on——

Dr. LEE. Outside the hospital, freestanding. Absolutely right.

Mr. MCGRATH. Certainly it is very interesting.

How is this going to be reconciled, the difference between your recommendation and that of HCFA?

Dr. LEE. We hope that you will accept our recommendations.

Mr. MCGRATH. So do the doctors.

Dr. LEE. The reason is that it represents, we think, a more realistic recommendation that is achievable.

We think if you have a recommendation that sets the volume performance standards too low, they simply become irrelevant. It means you are just jacking down the price without providing the incentive for reducing volume.

Mr. MCGRATH. The answer that Dr. Wilensky gave to Marty Russo regarding the glaring difference among the components that make up the percentage was that "other" category.

Do you have anything further to say about that?

Dr. LEE. We have set as a goal by 1996 to have the increase in expenditures at about the GNP increase and that we want to move gradually toward achieving that goal by reducing this "other" category which is volume and intensity. Our recommendation is a judgment about how rapidly the rate of increase in volume can realistically be reduced.

Mr. MCGRATH. When HCFA announces, as it did a few weeks ago, that for the first time, it is going to factor cost into quality and access in terms of its Medicare Program, what does that mean to you?

Dr. LEE. When Medicare evaluates what to pay for a new procedure, it looks not only at the effectiveness and the safety of the procedure, but also at the cost-effectiveness of that procedure.

Mr. MCGRATH. That is for new procedures?

Dr. LEE. Yes; that is my understanding.

Mr. MCGRATH. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I think one of the interesting things in your table 2 is where it shows under cataract surgery that the increase in volume for laser surgery is directly offset by the reduction in other cataract surgery.

The reason I point that out is because when laser surgery first came in, I am not an ophthalmologist, nor an expert in this area, but when it first came in, it was not broadly used because it was a new and difficult technique. It has taken a number of years to get to the point where this less invasive procedure can substitute for other surgeries.

One of the problems with technology assessment is that technologies often aren't sufficiently developed until use has refined there——

Dr. LEE. I would say that is the biggest problem with our drug policies, that we don't have a postmarketing surveillance system to evaluate adverse effects or new beneficial effects of drugs over time.

I think we need the same kind of surveillance system with respect to technologies.

We have learned that gastric freezing, which was done by a world renowned GI surgeon, turned out to be a totally useless procedure.

The laser surgery for secondary cataracts appears to be a safe and effective technology over time, but we need a monitoring system, which we don't have.

We have no way to really eliminate those procedures if they are judged to be ineffective. Certainly those that are effective as this laser surgery tend to be adopted and utilized.

Mrs. JOHNSON. I agree.

So you are saying that one of the tools that we need to control volume is a means of better assessing technology. Monitoring it over time is also important so that we can allow growth where growth is cost-effective and appropriate.

I thought an interesting part of your testimony was the tools for controlling volume.

I hear you saying that you support a more modest volume cap because our tools are, at this point, unrefined and not broadly available or useful. This touches very directly on the discussion that we had earlier in this hearing, that we had during the managed care hearing, and that we have had at several points throughout our subcommittee work.

You are clearly pointing to effectiveness and outcomes research, practice guidelines, profiling physicians, and patterns of practice as the tools for implementing volume reductions.

That certainly will have cost implications.

I think one of the reasons we are moving rather more gradually is so that these tools can get ever more refined.

Dr. LEE. The point that the chairman made earlier about data is an important one. If you had a single system of data collection, if all carriers were required to submit the information on the same forms, we could make marked improvements. We are 26 years into

Medicare and we have this availability of data that needs to be cleaned up.

We also need data on a much more timely basis.

We didn't get data on expenditures for 1990 until May 1991.

We should have a system that provides us with much more timely information, and then the volume performance standards could be linked in a much more timely way with physicians' actual practice.

Mrs. JOHNSON. I agree.

When we worked on hospital reimbursements for Medicare, we ran into this difficulty that we were basing decisions on outdated data.

One of the things that I included in my bill was a new approach to hospital management of data. The goal is to provide more timely data to preexamine procedures that are about to happen rather than postexamine them and, therefore, look at it from a reimbursement or nonreimbursement perspective.

Thank you for your testimony, Dr. Lee.

Chairman STARK. Phil, thank you very much.

I appreciate your work and the work the Commission does.

I continue to look forward to your help as we work through this issue this year.

Dr. LEE. You are welcome.

I would like to reemphasize the importance of the physician manpower issue in relation to expenditures. We intend to look very carefully at this issue over the next several years and hopefully to come back with information that will be useful to you in establishing some basic guidelines that can be used by the profession to set some limits on increases in specialties. Now, you can't do that because of Federal Trade Commission antitrust issues.

Chairman STARK. Mrs. Johnson had one further question.

Mrs. JOHNSON. I was recalling as you mentioned this last point that the Commission was going to do some work on malpractice and the implications of malpractice for costs and for volume.

How far along are you on that work?

Mr. GINSBERG. We are well into the work on malpractice.

In our annual report for 1991, we published a chapter showing where we have been so far. We are planning discussions for early fall designed to bring options before the Commission and have the Commission discuss them.

We anticipate that by our 1992 annual report that we would have a full series of recommendations for the Congress.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. The committee will recess for 5 minutes at which point we will have a panel of the physicians who are our final witnesses.

[Recess.]

Chairman STARK. And now our next witnesses comprise a panel from three physician's organizations. We are pleased to welcome Dr. Paul A. Ebert, the director of the American College of Surgeons; Dr. Harold Morris, representing the American College of Physicians, accompanied by Dr. Howard Shapiro; and Dr. Jerald

Schenken, a member of the board of directors of the American Medical Association.

Welcome to the committee, gentlemen, and lady, and please proceed, Dr. Ebert, and then the others may follow in the order in which you were introduced.

## STATEMENT OF PAUL A. EBERT, M.D., DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. EBERT. Thank you very much, Mr. Chairman, members of the committee.

I won't belabor reading the entire college testimony, but I would just like to emphasize several points that we think are terribly important. As you know, when Medicare physician payment reform legislation was considered by Congress, the college recognized the concern of the policymakers and wanted to have some influence on the process for reducing the rate of growth for services that were not appropriate.

Despite our strong support for the MVPS concept, I think the college still remains concerned about this process and how it is going to be used in the future. Certainly we, probably the same as the other organizations, have been disturbed by the unusually low MVPS's that were determined for this current fiscal year.

I am afraid that these rates of increase, which depart dramatically and rapidly from historical trends, may end up being somewhat inconsistent with what we thought was Congress' goal, and that was to have a reasonable reduction in the rate of growth for physicians' services under Medicare.

I think it would be very unfortunate at this time if physicians came to believe that the MVPS's have been set too artificially low in order to guarantee failure or to achieve too much budget reduction, so that we are going to have more difficulty at a time when this is still considered a somewhat fragile system.

I think we are concerned today to hear again that there are difficulties, so to speak, in even using the MVPS as a reasonable volume control tool, when it seems rather obvious that you have the majority of that tool in place—it is simply to be utilized.

So I guess I would say that we are troubled at the 1992 MVPS's recently recommended by the Secretary. They assume, without really much evidence, that the rate of growth in the volume of services can be reduced by about one-half in a very short period of time, without being really any more specific regarding the areas in which this reduction could take place.

Now, we also were worried when we heard again this afternoon that the 1992 MVPS rates of increase couldn't be set separately for surgical or nonsurgical targets simply because of data problems. When we started having discussions with HCFA regarding the definition of surgical services, there were some accommodations made on both sides really, with the idea that these data were available and could be utilized in such a fashion.

We were not unhappy with the definition of surgical services, but we are a little concerned, so to speak, that at this time they can't truthfully be separated. So, I believe that if the most important aspect of this concept is for the physician and surgical communities

to have some type of feedback mechanism to their peers regarding volume growth, then there has to be some reasonably rapid return of information to these groups.

The statement has been made that the MVPS, per se, has had no impact whatsoever at this point on physician behavior. I don't find that to be surprising because it has only been in place a short time. I think many members of this committee said last year that the MVPS, in itself, would not do anything to change behavior, and we totally agree with that.

So I think the information provided from the department probably will be the most important single factor, so to speak, affecting how successful surgeons or physicians are going to be in looking at behavioral adjustment within our profession.

I would just like to comment briefly on three other points that we mentioned. One is the Nation's supply of surgeons. I think we provided you with a table showing that, basically speaking, the growth in surgical manpower has really been very modest and way below the GMENAC projections.

I think the bundling of surgical services is going to be well-defined, and we have no complaints about this.

The use of assistants at surgery is still a little bit of a concern because it looks too much like microlegislative management of an issue that probably should be a medical decision. We agree with you that there should not be reimbursement for certain operations in which an assistant clearly is not indicated, and the college, together with the surgical specialty societies, has put together a listing that we provided to HCFA showing that there were over 1,300 surgical codes for which no assistant should generally be considered. But there are exceptions to the rule, and even things at the 5-percent level sometimes are a little bit difficult if the particular patient happens to be oversized or in particularly bad health. So, we are concerned that maybe too much focus is being placed on a small issue.

We certainly appreciate the opportunity of presenting our written testimony. We again stand willing to help, but we would like to be able to get good information feedback in a reasonably rapid time.

[The prepared statement follows:]

STATEMENT

OF THE

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health
Committee on Ways and Means
House of Representatives

Presented by

Paul A. Ebert, MD, FACS

RE: Medicare Cost Controls

May 21, 1991

Mr. Chairman and Members of the Subcommittee, I am Paul A. Ebert, MD, FACS, and I am the Director of the American College of Surgeons. On behalf of the more than 51,000 Fellows of the College, I am pleased to have this opportunity to present our views with regard to the recent recommendations that relate to Medicare Volume Performance Standards (MVPSs) for surgical and all other physicians' services, the Medicare fee update for services that are provided on or after January 1, 1992, and other issues that are directly related to the volume of physicians' services under Medicare.

As you know, when the Medicare physician payment reform legislation was being considered by Congress, the College recognized the concerns of policymakers with regard to trends in the volume of physicians' services. We supported Congress's decision to include a mechanism for addressing these concerns in the physician payment reform plan--in particular, the provision for a separate MVPS for surgical services.

We also have worked closely with the Health Care Financing Administration (HCFA) to implement this separate MVPS. Among other things, the College provided recommendations for a definition of surgical services that would apply under the MVPS. Moreover, we provided advice with regard to the technological advances in surgery that would have a direct bearing on patients' demands (both increasing and decreasing) for surgical services. This special report, which is entitled "Changes in Technology Affecting Surgery," is the result of the deliberations of representatives of the College and the surgical specialty societies. The report was completed in March 1991 and submitted to HCFA and to the Physician Payment Review Commission (PPRC). We also provided a copy of the report to the Committee staff. As with all efforts in this area, we recognize that the report is limited by the methodologies that are available to quantify the effects of health care technology on Medicare expenditures for physicians' services. Nevertheless, we hope that this effort will prove to be helpful to policymakers.

The Issue of Reasonableness

Despite its strong support for the MVPS concept, the College remains concerned about the use of the MVPS process now and in the future. We were disturbed by the unusually low MVPSs that were determined for the current fiscal year--only 3.3 percent for surgical services and 8.6 percent for all other physicians' services. Not only do these rates of increase depart drastically and rapidly from historical trends, but also they are inconsistent with what we perceived to be Congress's goal of imposing reasonable "expenditure targets" for physicians' services under Medicare. It would be unfortunate if physicians were to believe that the MVPSs are set artificially low in order: (1) to guarantee their failure and (2) to provide a rationale for restricting increases in Medicare fees even though increases are justified by higher physicians' practice costs and the cost of living in general.

In this regard, the College was disappointed by Congress's mandate to reduce by two percentage points the FY 1991 MVPSs that would have been imposed if only increases in the beneficiary population, fee increases and other payment policy changes mandated by the

Congress, and related factors had been taken into account. As a result, despite the fact that the Secretary of Health and Human Services (HHS) has estimated that Medicare expenditures for nonsurgical services would be expected to increase in FY 1991 at *fully twice* the rate of spending growth for surgical services (10.6 percent compared to 5.3 percent), the same two percentage point reduction was mandated for both surgical and nonsurgical services. This across-the-board reduction obviously has more significant implications for a baseline rate of growth of 5.3 percent--a 38 percent reduction in the rate of growth--than it does for a baseline rate of 10.6 percent--a 19 percent reduction. In effect, the category of services with the lower rate of growth is disproportionately penalized. We urge the Congress to take steps that would avoid this kind of outcome.

We also are troubled by the FY 1992 MVPSs recently recommended by the Secretary. These recommendations assume--without any evidence--that the rate of growth in the volume of services can be reduced by one-half in a short period of time without any negative consequences for Medicare beneficiaries. They appear to ignore the fact that support of the physician community for the MVPS concept is fragile, even within the surgical community. We note that the PPRC shares our concerns and has recommended substantially higher MVPSs for FY 1992.

While the College continues to support the MVPS concept, we believe that unrealistically low and unattainable standards will undermine our attempt to work with the Congress and the Administration to develop programs that will ensure that the Medicare population receives optimum surgical care. Moreover, our previously noted concerns with regard to the disproportionate effect of the MVPS calculations on services with lower rates of growth also apply to the FY 1992 recommendations. These calculations once again produced recommendations with a sizable differential between surgical services and all other physicians' services--4.1 vs. 7.1 percent. In other words, the MVPS being recommended for nonsurgical services is more than 70 percent higher than that for surgical services. As with last year's standards, the category of service with the lower rate of growth in expenditures is penalized by the MVPS formula.

The Issue of Separate Updates

The Secretary's recommendations for the 1992 MVPS rates of increase and the Medicare fee updates also contained another surprise for the surgical community; that is, the Secretary announced that he is unable at the present time to estimate the percentage growth in Medicare expenditures for surgical services using the definition of surgical services that was adopted by the Administration. As a result, the Secretary's recommended update for 1992 does not distinguish between surgical services and all other physicians' services.

This announcement was unexpected. During the discussions with regard to the most appropriate definition of surgical services under the MVPS, an important consideration was the feasibility with which the definition could be administered. While the College would have preferred a definition based at least partially on procedure codes, we were advised that this approach would not be possible in the short-term. As an alternative, it was noted that a definition based on "type of service" indicators on payment records would be feasible, and the College strongly supported this approach. As we understand it, Secretary Sullivan and members of his staff repeatedly advised this Committee and other members of Congress during the formulation of the Omnibus Budget Reconciliation Act of 1989 that HCFA would be able to distinguish between surgical services and all other physicians' services. In the end, for purposes of the MVPS, surgical services were defined to include all services that are categorized as surgery in the Medicare payment record and performed by any one of several surgical specialties.

Now, the Secretary has indicated that he is unable to make a separate estimate of the percentage growth in surgical services "because of limitations in our current data systems," adding that he expects to be able to do so in "future years" using the new national claims history files, better known as the Common Working File. The College is troubled by the fact that, although the definition of surgical services was selected precisely in order to circumvent limitations in the current data systems, the Secretary has offered virtually no explanation for the inability to perform the requisite calculations. Moreover, there appears to be at least some possibility that data limitations again may make separate calculations impossible in the next year or two.

At the urging of the College, the Congress specifically provided separate MVPSs for surgical and for all other physicians' services. In addition, the Congress gave the Secretary the authority to recommend separate Medicare update factors based, at least in part, on actual performance under these separate standards. We are concerned that ill-defined data limitations may make a mockery of the separate MVPSs, and we urge you to see that HCFA takes the steps that are necessary to ensure that separate expenditure growth comparisons are feasible next year.

Issues Related to Volume of Services

Mr. Chairman, I would next like to take a few moments to discuss three issues that the College believes are directly relevant to the Committee's deliberations pertaining to the volume of physicians' services. These issues are: (1) the nation's supply of surgeons; (2) the bundling of physicians' services; and (3) the use of assistants at surgery.

It may come as a surprise to this Committee that the number of surgical residents has remained quite stable over time, as noted in the recently published *Longitudinal Study of Surgical Residents*. In fact, as shown in the attached table, the number of surgical residents has tended to decline over the last decade, from a total of 21,136 in 1982/83 to 20,453 in 1989/90. Moreover, the latter count is far below the original projection of 25,000 surgical residents in 1990, which was made by the Graduate Medical Education National Advisory Committee (GMENAC).

For example, the table shows that GMENAC significantly overestimated the number of general surgery residents in 1990. GMENAC predicted there would be 9,200 general surgery residents that year. However, the actual count for the 1989/90 academic year was 7,799 residents in general surgery. This comparison supports the College's longstanding view that GMENAC's projections of an oversupply of general surgeons were incorrect. Moreover, as you may know, the Council on Graduate Medical Education (COGME) recently contracted with Abt Associates, Inc., to update GMENAC's physician manpower projections through the year 2010 for six physician specialties, including general surgery. Although the College continues to question some components of GMENAC's methodology, we agree with the Abt report's conclusion that general surgeons are likely to be substantially in undersupply during the next 20 years. This conclusion is consistent with the College's longitudinal study, which shows that the actual number of general surgeons in training has decreased over the past decade. It also is consistent with a report that was issued by the American Medical Association in 1988, which indicated that general surgery is one of a very few specialties in which the growth in the utilization of services is likely to exceed the growth in the supply of physicians.

A second issue relates to the potential for increased use of service bundles. As you know, for many years, the typical way in which surgical services have been reimbursed by third party payers is under a global fee. This fee covers the procedure itself, together with various aspects of pre- and postoperative care. This payment approach has precluded the need to bill separately for each service, such as individual post-operative visits, even when they are provided weeks and even months after the operation itself. As part of Medicare physician payment reform, efforts are underway to standardize the contents of the global surgical fee bundle. The PPRC has played an important role in this effort, and the College has been pleased to provide advice about this matter.

I also would like to comment briefly with regard to the use of assistants at surgery. As you know, PPRC's 1991 report includes several recommendations regarding Medicare payments for the services of assistants at surgery. Among other things, the Commission points out that data problems may have caused HCFA to prohibit payment for assistance at surgery in the case of certain services for which an assistant is clearly medically indicated, either generally or in the case of specific patients. The College urges you to re-examine this entire issue. It is our strongly held view that assistant-at-surgery services should be covered under Medicare *whenever they are medically necessary*, and that they should be paid under the same valuation rules that apply to all other physicians' services. We recognize, of course, that any policy changes in this area will need to be taken into account under the MVPS.

The Future of the MVPSs

Finally, I would like to call attention to two issues that will become increasingly important under the MVPSs. First, there has been discussion with regard to moving away from national volume performance standards to a form of sub-national standards. The College urges policymakers to approach this issue with great caution. We believe that additional experience with national standards is necessary before there can be any thoughtful discussion about the advantages and disadvantages of considering alternative approaches. In particular, we have had discussions with HCFA to determine if it will be possible to obtain timely feedback of actual performance data to the surgical community. If the College and the surgical specialty societies are to assist in making the MVPS concept have any meaningful impact, it will be necessary to have regular, ongoing discussions with regard to the volume of services performed. Clearly, HCFA must be capable of providing these data if the surgical community is to attempt to examine and influence surgeons' behavior. The College has indicated to HCFA its desire to participate actively in such a feedback process.

Moreover, we believe that sub-national standards are fraught with methodological difficulties. In setting sub-national standards, there is a much greater risk that Medicare beneficiaries in one or more regions of the country will be disadvantaged, simply as a result of differential increases in the Medicare population due to migration, geographic differences in medical care utilization rates over time, or other factors. For example, an area of the country where there has been a relative underuse of services over time could be penalized under sub-national volume performance standards as could an area experiencing an explosive growth in the Medicare beneficiary population.

Finally, the College believes that the statutory requirement for a separate MVPS for surgical services also has a direct bearing on the mechanisms that ultimately are adopted to determine relative values for new surgical services and to adjust relative values for those that currently are provided. As we understand it, HCFA is considering methods by which to determine new and revised relative values for surgical services and for all other physicians' services. Among other things, the agency is considering the most appropriate role that physician organizations can play in this process. It is the College's strongly held view that, regardless of the mechanism that ultimately is adopted, it will be necessary to consider separately each category of physicians' services subject to its own MVPS. Since separate MVPSs make differential fee updates possible over time, we believe it would be more practical for physicians to recommend--or for policymakers to determine--new and revised relative values by comparison to the relative values of other services in the same category.

Conclusion

Mr. Chairman, in closing I would like to emphasize the fact that the American College of Surgeons remains supportive of the MVPS concept. However, we are increasingly concerned that unreasonable standards will severely undermine our efforts to make the concept work as we believe it was intended. In particular, we believe that unreasonable standards for surgical services, following on the heels of years of Medicare payment reductions for many surgical services, will almost surely guarantee the repudiation and failure of this volume control mechanism.

The College appreciates this opportunity to present our views once again, and we look forward to continuing to work with the Committte toward fair and successful implementation of Medicare physician payment reform.

Chairman STARK. You are not alone. Dr. Morris.

**STATEMENT OF J. HAROLD MORRIS, JR., M.D., CLINICAL PROFESSOR OF MEDICINE, UNIVERSITY OF MISSOURI, KANSAS CITY SCHOOL OF MEDICINE, AND MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF PHYSICIANS, ACCOMPANIED BY HOWARD B. SHAPIRO, PH.D., ACTING DIRECTOR OF PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS**

Dr. MORRIS. I am J. Harold Morris, Jr., M.D., F.A.C.P., a member of the board of regents and former governor of the college for Missouri. I am in full-time private practice in general and internal medicine in Independence, MO.

The college represents over 70,000 physicians practicing internal medicine and its subspecialties. The college recognizes that Medicare part B expenditures have been one of the fastest-growing components of the Federal budget and that the rate of increase in spending must be curtailed.

We are, however, concerned that efforts to ratchet down expenditures for physician services are undermining efforts to achieve physician payment reform, and will lead to an unrealistically discounted Medicare fee schedule. The provisions of OBRA 1989 and OBRA 1990, creating volume performance standards and limiting increases in physician payments, as well as past reductions, are offsetting the needed improvements in Medicare payments for evaluation and management services that were anticipated with implementation of the Resource-Base Relative Value Scale.

The college and many other medical organizations are now actively involved in developing guidelines or parameters of medical practice.

Despite this encouraging progress, at this point in time we know relatively little about the appropriateness of many medical procedures, and we have little scientific data about expected outcomes.

Consequently, even though the statute is explicit in stipulating that changes in technology and evidence of inappropriate utilization are among the factors that should be considered in developing recommendations for the MVPS, neither the recommendations of the PPRC nor those of the Secretary of HHS are based on quantitative assessments of the extent of inappropriate utilization or determinations of the appropriate rate of growth in the volume and intensity of medical services.

There is no question that we need to pay attention to the question of volume, but we must do so carefully, with attention to the data. Recent information from the PPRC indicates how complex this issue is. For example, the chart attached to our testimony indicates a reduction in the rate of growth in Medicare Physician expenditures from 1984 to 1988, almost exclusively due to controls on the price side. Volume remained steady, casting doubt on claims that physicians increase utilization in response to fee freezes or cuts in an attempt to maintain income.

The new report from PPRC on the fee update and MVPS raises additional questions and reinforces a perception of the complexity of this issue. For example, visits and consultations are among the slowest-growing services, but so are most surgeries.

In analyzing trends in volume, the split seems not to be surgical versus nonsurgical, or one speciality versus another. Highest growth is in high-technology procedures, some medical and some surgical. Further investigation of these trends is necessary. We caution against action applied indiscriminately across specialities or groups of services, in light of these data which indicate a need for much more refined distinctions.

We wish to emphasize the danger of adopting a physician fee update for calendar year 1992 that is too low. Implementation of RBRVS, beginning in 1992, follows 7 years of freezes, limits, and reductions in Medicare physician fees.

Although Medicare payments for physician services may become more equitable relative to one another, payment levels overall will still reflect past cost reductions. The PPRC has documented how this will hold RBRVS payments for primary care to discouragingly low levels.

Consequently, we are disappointed that both the Secretary of HHS and the PPRC chose to recommend that Congress follow the default mechanism provided in OBRA 1989 for setting the fee updates for 1992. The update would be reduced by the 1.5-percent difference between the 10.6-percent actual growth in fiscal year 1990 expenditures and the 9.1-percent MVPS for fiscal year 1990, yielding an update of only 2.2 percent.

We believe it unwise to cut payments further as Medicare begins the transition to the RBRVS fee schedule. In light of the recent history of payment reductions, the startup of the RBRVS transition, and the lack of sufficient opportunity for physicians to respond to the fiscal year 1990 MVPS, we suggest that Medicare fees in 1992 should be increased by the full 3.7-percent increase in the Medicare Economic Index.

Mr. Chairman, we are particularly concerned that the recent history of annual adjustments that do not fully reflect physician practice costs is creating a discounted Medicare fee schedule that, like Medicaid, provides payments that are substantially below those for non-Medicare patients.

This may produce a system, like Medicaid, where physicians are reluctant to accept new Medicare patients and access to physician services will be limited for Medicare beneficiaries. We believe that the MVPS recommendations for fiscal year 1992, especially those of the Secretary, are unrealistically low, and most likely unattainable. They are likely to trigger further cutbacks in physician payment levels in subsequent years.

We urge the subcommittee to reject the recommendations of the Secretary. The MVPS should serve as a steady, moderate influence pushing expenditures lower. A downward trend line, even incrementally, would be a significant achievement. An MVPS at a level such as that recommended by the PPRC or that which the default mechanism would produce is an appropriate and realistic goal.

Both the Secretary and the PPRC acknowledge the limitations of their current ability to measure appropriateness and to determine an acceptable rate of growth in volume and intensity.

We do not agree that half of the growth should be considered inappropriate without substantiating data. We urge the subcommit-

tee to be more cautious, as the PPRC has been, allowing the MVPS to accommodate reasonable growth in volume and intensity.

[The prepared statement follows:]

**STATEMENT OF THE**
**AMERICAN COLLEGE OF PHYSICIANS**
**BEFORE THE**
**HOUSE WAYS AND MEANS COMMITTEE**
**SUBCOMMITTEE ON HEALTH**

**May 21, 1991**

**Medicare Physician Fee Update, MVPS, and Other Volume Issues**

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to outline our views on the 1992 Medicare physician fee update, the FY 1992 Medicare Volume Performance Standard, and other issues related to the volume of physician services. I am J. Harold Morris, Jr., M.D., F.A.C.P., a member of the Board of Regents and former Governor of the College for Missouri. I am in full-time practice and also serve as Clinical Professor of Medicine at the University of Missouri Kansas City School of Medicine. Accompanying me is Howard B. Shapiro, Ph.D., Acting Director of Public Policy for the College.

The College represents over 70,000 physicians practicing internal medicine and its subspecialties. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, cardiology and geriatric medicine; medical educators; and researchers.

The College recognizes that Medicare Part B expenditures have been one of the fastest growing components of the federal budget and that the rate of increase in spending must be curtailed. We are, however, concerned that efforts to ratchet down expenditures for physician services are undermining efforts to achieve physician payment reform, and will lead to an unrealistically discounted Medicare fee schedule. The provisions of OBRA '89 and OBRA '90, creating volume performance standards and limiting increases in physician payments, as well as past reductions, are offsetting the needed improvements in Medicare payments for evaluation and management services that were anticipated with implementation of the Resource-Based Relative Value Scale (RBRVS).

Current efforts to set volume performance standards are hampered by inadequate data and insufficient knowledge about the appropriateness of care. Although we all recognize that some of the growth in the volume and intensity of medical services is due to inappropriate utilization of services, we are just beginning to direct sufficient resources on a national level to develop the tools to distinguish which services are effective and appropriate and which are not.

**Guidelines and Inappropriate Care**

As we have testified to this Subcommittee on previous occasions, since 1976 the College has been actively involved in seeking to reduce the amount of inappropriate medical care by developing and disseminating to the profession scientific data on the clinical efficacy and effectiveness of medical tests and procedures. Initially, working in cooperation with the Blue Cross and Blue Shield Association through the Medical Necessity Project, the College focused on evaluating the medical necessity of new procedures of unproven value and established procedures of questionable usefulness. In 1981, under a demonstration project funded by the John A. Hartford Foundation, we started the Clinical Efficacy Assessment Project (CEAP), developing clinical evaluations and practice guidelines using scientifically-based information to reduce the areas of uncertainty in medical practice. Since 1984, funding to continue CEAP has been provided from general College revenues. To date, in over a decade of working continuously to improve the process for guidelines development, the College has developed over 50 guidelines and dozens of additional, related reports.

Many other medical societies are now actively involved in developing guidelines or

parameters of medical practice. As you are well aware, Mr. Chairman, the federal government has committed millions of dollars through the new Agency for Health Care Policy and Research to the development of guidelines and the research necessary to support their development. That agency's work is just now starting.

Despite this encouraging progress, at this point in time we know relatively little about the appropriateness of many medical procedures and we have little scientific data about expected outcomes of many medical interventions. Thus, it is difficult, if not impossible, to identify much of what is believed to be inappropriate care. Consequently, even though the statute is explicit in stipulating that changes in technology and evidence of inappropriate utilization are among the factors that should be considered in developing recommendations for the MVPS, *neither the recommendations of the Physician Payment Review Commission nor those of the Secretary of the Department of Health and Human Services are based on quantitative assessments of the extent of inappropriate utilization or determinations of the appropriate rate of growth in the volume and intensity of medical services.*

**The Complexity of Restraining Growth in Utilization**

There is no question that we need to pay attention to the question of volume, but we must do so carefully, with attention to the data. Recent information from the PPRC indicates how complex this issue is. For example, the chart attached to our testimony (taken from PPRC's 1991 Report to Congress) indicates a reduction in the rate of growth in Medicare physician expeditures from 1984 to 1988, almost exclusively due to controls on the price side. Volume remained steady, casting doubt on claims that physicians increase utilization in response to fee freezes or cuts in an attempt to maintain income.

The new report from PPRC on the fee update and MVPS, presented with exceptional data and analysis that has become the hallmark of PPRC, raises additional questions and reinforces a perception of the complexity of this issue. For example, visits and consultations are among the slowest-growing services, but so are most surgeries. In analyzing trends in volume, the split seems not to be surgical v. non-surgical, or one specialty v. another. Highest growth is in high technology procedures, some medical and some surgical. Further investigation of these trends is necessary. We caution against action applied indiscriminately across specialties or groups of services, in light of these data which indicate a need for much more refined distinctions.

**1992 Medicare Fee Update**

Today, we wish to emphasize the danger of adopting a physician fee update for calendar year 1992 that is too low. Implementation of the RBRVS, beginning in 1992, follows seven years of freezes, limits, and reductions in Medicare physician fees. Under existing budget neutrality provisions, the net cost of physician payments in FY 1992 under the partially phased-in, RBRVS fee system must not be any greater or less than projected growth under the previous, totally charge-based system. Thus, although Medicare payments for physician services may become more equitable relative to one another, payment levels overall will still reflect past cost reductions. The PPRC has documented how this will hold RBRVS payments for primary care to discouragingly low levels.

Consequently, we are disappointed that both the Secretary of HHS and the PPRC chose to recommend that Congress follow the default mechanism provided in OBRA '89 for setting the fee updates for 1992. As you are aware, this would mean that physicians would not receive the full 3.7% increase in the Medicare Economic Index (estimated at 4.1% minus 0.4% to reflect OBRA '90). Instead the update would be reduced by the 1.5% difference between the 10.6% actual growth in FY 1990 expenditures and the 9.1% MVPS for FY 1990, yielding an update of only 2.2%. Reducing the 1992 update to this level will further widen the gap in payment levels between Medicare and private payers.

We believe it unwise to cut payments further as Medicare begins the transition to the RBRVS fee schedule. Many physicians are already apprehensive that their Medicare payments, despite the budget neutrality provisions, will be reduced. The threatened behavioral offset contemplated by HCFA may indeed make this fear a reality. We also

argue against holding physicians strictly accountable on a one-for-one basis to a performance standard in its first year of operation--especially since the MVPS did not become operational until well into the fiscal year. In light of the recent history of payment reductions, the start-up of the RBRVS transition, and the lack of sufficient opportunity for physicians to respond to the FY '90 MVPS, we suggest that Medicare fees in 1992 should be increased by the full 3.7 percent increase in the Medicare Economic Index.

Mr. Chairman, we are particularly concerned that the recent history of annual adjustments that do not fully reflect physician practice costs is creating a discounted Medicare fee schedule that, like Medicaid, provides payments that are substantially below those for non-Medicare patients. The PPRC has indicated that the gap between Medicare and Blue Cross/Blue Shield plans has now widened from 18% in 1987 to 22% in 1989. This may produce a system, like Medicaid, where physicians are reluctant to accept new Medicare patients and access to physician services will be limited for Medicare beneficiaries. I have heard colleagues say that this is already happening among established and new physicians alike.

**FY 1992 Volume Performance Standards**

We believe that the MVPS recommendations for FY '92, especially those of the Secretary, are unrealistically low, and most likely unattainable. They are likely to trigger further cutbacks in physician payment levels in subsequent years. An MVPS that is set too low will jeopardize future physician payment fee schedule updates and prompt further downward adjustments in the conversion factor, leading to an unrealistic fee schedule.

We urge the Subcommittee to reject the recommendations of the Secretary. The MVPS should serve as a steady, moderate influence pushing expenditures lower. A downward trend line, even incrementally, would be a significant achievement. An MVPS at a level such as that recommended by the PPRC or that which the default mechanism would produce is an appropriate and realistic goal.

In developing their recommendations for the FY '92 MVPS, the PPRC and the Secretary agreed on all estimates for the factors specified in the statute, except for the category of "other factors", which represents the combined effects of technology, access and utilization on the growth in volume and intensity of services. Both the Secretary and the PPRC acknowledge the limitations of their current ability to measure appropriateness and to determine an acceptable rate of growth in volume and intensity. The Secretary notes:

> In summary, we have encountered many difficulties in measuring the effects of technology on expenditure growth. It is not currently possible for the Department of Health and Human Services to quantify the effects of technology on total expenditures for physician services nor to separately determine an allowance factor for this in the MVPS.

The Secretary goes on to explain that studies are underway to improve understanding of technological innovations on Medicare spending, and data systems are being developed to better track changes in expenditures by procedure. The Secretary also discusses the difficulty in measuring inappropriate utilization. Although he admits that a precise estimate of the extent of inappropriate utilization is not possible, he arbitrarily assumes that half of the historical rate of growth in volume and intensity is attributable to inappropriate utilization. Thus the recommended factor for growth in volume and intensity is 3.7%--one-half of the 7.4% estimated annual growth in expenditures for the period FY 1986-90 not attributable to inflation, enrollment or aging.

We contend that the estimations of projected growth for these "other factors" representing volume and intensity (PPRC: 6.1%; HHS Secretary: 3.7%) must be viewed as very rough estimates at best. We do not agree that half of the growth should be considered to be inappropriate without substantiating data. We urge the Subcommittee to be more cautious, as the PPRC has been, allowing the MVPS to accommodate reasonable growth in volume and intensity that reflects justifiable increases due to technological innovations,

changes in medical practice, improvements in access to services, and other causes.

**Strategy for Reducing the Rate of Growth in Volume**

To comment briefly on efforts beyond the MVPS that can reduce volume growth, we would reiterate our position that the answer lies in continuing to work for systemic reforms of the health care system. In the short term, we can push forward with the development of guidelines and better information on the appropriate utilization of medical services. We recognize that guidelines development and further research will not produce immediate budget savings, and we do not propose these primarily as a means of cost containment. As we outlined in testimony before this Subcommittee three weeks ago, practice guidelines and outcomes research can play an important role in ensuring that the American public, including Medicare beneficiaries, are getting value for their health care dollars.

However, as we argued at that hearing, comprehensive reform of the health care system will be necessary to moderate the effects of the major financial and other incentives which currently push physicians and others to deliver more services. In that testimony, we elaborated on some of the obstacles in the current system that discourage the use of guidelines: the payment system, the lack of a national physician manpower policy, investment incentives, professional liability considerations, utilization review processes, and the role of the patient.

We urge you to push ahead with your efforts to achieve consensus on overall reform. One particularly promising area for legislation in the near term which can help to reduce overutilization is liability reform. We hope the Subcommittee will use the opportunity of the President's endorsement last week of a major federal liability initiative to achieve bipartisan agreement in this area.

We argued in 1989 that habits, incentives, and pressures of several decades cannot be reversed overnight. We know this is not a very satisfying answer in light of the budget pressures you face and continuing cost escalation of the overall system. A realistic MVPS may in the short term be able to help moderate this growth. But only the hard work of comprehensive reform will set us on the path to sustained levels of appropriate utilization of services.

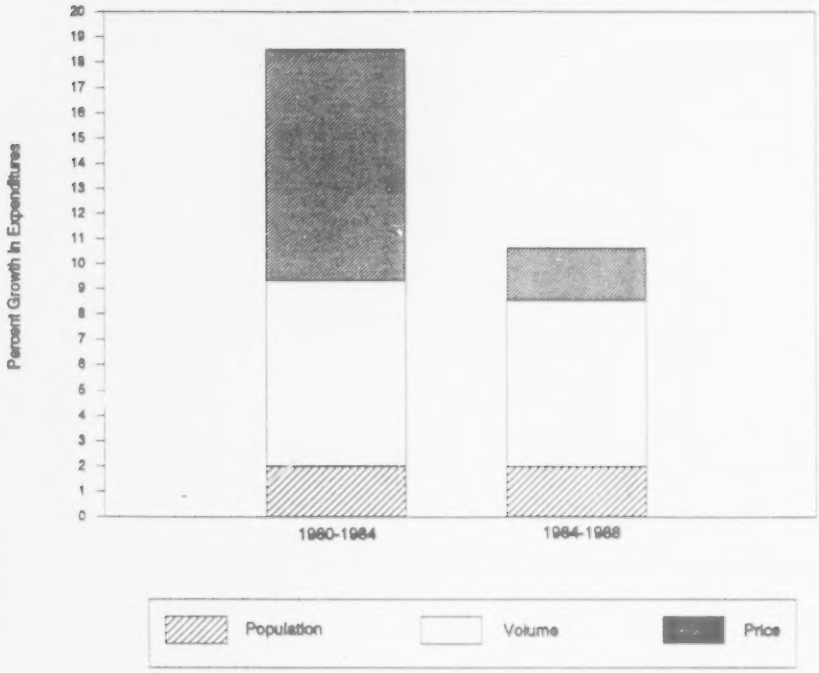
**Conclusion**

The College urges the Subcommittee to consider the impact of the various cost reduction measures over the past seven years, the danger of the Medicare fee schedule becoming unrealistically low, and the peculiar circumstances of 1992 as a transitional year. We urge you not to allow the fee update to be determined by default, but to take action permitting fees to rise appropriately by the full 3.7% increase justified by the adjusted Medicare Economic Index.

We have also outlined some of the limitations of current efforts to measure inappropriate utilization of health care services and to project appropriate rates of growth in the volume and intensity of medical services. We have discussed some of the efforts, including our own, to improve medical practice through the use of scientific data on clinical effectiveness, outcomes research, and practice guidelines. As we have testified previously, these need to be encouraged in the context of comprehensive health systems reform. On a short-term basis, the MVPS may help to moderate expenditure growth if it is set at a realistic, achievable level. An appropriate level would approximate that recommended by the PPRC or that produced by the default mechanism. Lower levels unsubstantiated by data would be punitive only, and counteract incentives for physicians to work with HCFA, the AHCPR, and other government agencies to reduce the volume of services.

Thank you.

Figure 1-6. Growth in Medicare Physician Expenditures by Components 1980 - 1988




Source: PPRC, 1990.

Chairman STARK. Thank you.

We have a vote, and I guess we have about 10 minutes left. I am going to suggest that, rather than rush through the next witness, we recess for about 6 minutes.

We will vote and will resume as soon as we get back.

[Recess.]

Chairman STARK. We will go back on the record.

Dr. Schenken, would you like to enlighten us?

**STATEMENT OF JERALD R. SCHENKEN, M.D., SECRETARY-TREASURER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION**

Dr. SCHENKEN. Thank you, Mr. Chairman. My name is Jerald R. Schenken. I am a private practicing physician in Omaha in the speciality of pathology. I am also secretary-treasurer of the board of trustees of the American Medical Association.

With me today is Janet Horan from the AMA's Division of Federal Legislation. In the interest of time, I am going to shorten my statement a little bit.

The association is pleased to appear before you to discuss MVPS and the payment update. The AMA believes that the MVPS process can be used as a method of encouraging improved understanding of the causes of expenditure growth for physician services covered by Medicare.

Further, we believe this process provides the basis for Congress to consider all the elements of Medicare part B expenditure growth in setting the update factor each year under the new Medicare payment schedule.

Our basic message today is that inherent imprecision in projecting the volume of Medicare services necessitates that an acceptable range be built around any MVPS number. There are a number of alternatives to the HHS/PPRC actuarial methods used to forecast part B physician expenditure growth.

Total expenditures for a year can be broken down into the following components—changes in enrollment, changes in Medicare payment for each service, and changes in volume of services per enrollee.

Using well-documented expenditures of utilization responses to specific changes in the status of the Medicare beneficiary population, AMA research has shown that the average annual percentage increase in part B physician expenditures can be fully explained.

This approach also can be used to predict future growth in part B expenditures necessary to maintain appropriate beneficiary access. Although the HHS/PPRC and AMA forecast results are similar, the different nature of the methods used has clear implications for an alternative to the HHS/PPRC approach of establishing the MVPS by arbitrarily reducing the unexplained residual. That is, volume and intensity of services.

Specifically, the access-based approach accounts for detailed economic and demographic changes that are elements of this residual. It directly contradicts the HHS position that there is a lack of direct causal explanation for some 7.4 percentage points of the projected increase.

Because of the inescapable forecasting error inherent in all of the projecting methodologies and because of the demonstrated difficulty in reconciling forecasts with actual outcome, the association believes that the MVPS should recognize an acceptable range of expenditure increase of 10.3 percent—plus or minus 2.1 percent—for 1992 rather than a single number, as HHS and PPRC have recommended.

Congress should contemplate reducing the conversion factor update only if the actual expenditure increase exceeds this forecast range. The AMA also recommends that the 1992 conversion factor update be set at the full MEI. That is 4.1 percent. This recommendation reflects the inherent imprecision in the 1990 MVPS. Also, this first MVPS was not issued until the second quarter of 1990, and there was little opportunity for physician education or response.

The quarterly progress reports required by statute, which would have allowed physicians to identify problems and initiate corrective action were not published. There should be no reduction due to the fact that the 1990 expenditures exceeded the 1990 MVPS by 1.5 percent, which is well within the expected error of forecast underlying the 1990 MVPS.

In conclusion, Mr. Chairman, our health care system is costly, and it continues to require more and more of our attention and our resources. The AMA continues to address the volume and intensity of health care services through various measures, such as practical parameters, technology assessment, outcomes research, and liability reform.

The AMA is dedicated to establishing valid, reliable information to be used in evaluating the components of Medicare expenditures.

We know that HHS and PPRC will continue their serious efforts to research this issue. This research is especially important if the factors driving volume increases can be understood so that policymakers can make informed decisions and physicians can develop appropriate responses to those causes of volume growth that are within their control.

Let me just emphasize that, so physicians can develop appropriate responses to those causes of volume that are within their control. Without such information, decisions will be made based on speculation and conjecture rather than on facts.

We urge the committee to continue its strong support of prompt results. Thank you, Mr. Chairman, and we will be available to participate in the question process.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

RE: THE VOLUME OF PART B SERVICES AND THE MEDICARE VOLUME PERFORMANCE STANDARD

PRESENTED BY
JERALD R. SCHENKEN, M.D.

May 21, 1991

Mr. Chairman and Members of the Subcommittee:

America's elderly and disabled patients are recipients of a quality and level of health and medical care services undreamed of when the Medicare program was initiated over a quarter of a century ago. We point with pride to a population that is far healthier than any past generation of elderly or disabled patients. We see this as a "good news" story, but one that also reflects the growing expense of fulfilling the Medicare promise. Of course, these expenses should be closely examined.

As part of this careful review, the American Medical Association (AMA) is pleased to appear before you to discuss the Medicare Volume Performance Standard (MVPS) and payment update. The AMA believes the MVPS process can be used as a method to encourage improved understanding of the causes of expenditure growth for physician services covered by Medicare. Further, we believe this process provides the basis for Congress to consider all of the elements of Medicare Part B expenditure growth in setting the update factor each year under the new Medicare payment schedule.

Reflecting the Association's support for the MVPS process, we are pleased to report to Congress on our specific recommendation for the MVPS and update for 1992. For the MVPS, we recommend 10.3%, plus or minus 2.1%. As you know, the Secretary of the Department of Health and Human Services (HHS) has recommended that the MVPS be set at 6.2% for FY 1992. The Physician Payment Review Commission (PPRC) has recommended a FY 1992 MVPS of 8.6%. The current estimate of the "default" MVPS, if Congress does not act, is 8.4%. (Table I and Figure I contain a comparison of all of the FY 92 MVPS recommendations.)

We believe that these different recommendations demonstrate the imprecision in making such a projection. As a result, we believe it imperative to interpret the MVPS as a range that will reflect reasonable alternative directions and assumptions for setting the MVPS. Congress should contemplate reducing the conversion factor update only if the actual expenditure increase exceeds this forecast range.

For the 1992 update, we recommend 4.1%, the full value of the 1991 Medicare Economic Index (MEI).* Both HCFA and the PPRC have recommended a default 1992 conversion factor update estimated at 2.2%.

In the remainder of our statement, we will outline the basis for our recommendation as well as our view on current efforts to analyze and reduce health care costs and the volume of services.

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*This reflects the current AMA projection of the MEI of 4.5% before the 0.4% reduction mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). The 4.5% AMA projection is 0.4% higher than that recognized by HHS and PPRC.

HHS/PPRC Projection Methodology

Both HHS and the PPRC employ actuarial methods to project Part B expenditure growth. This approach recognizes two groups of factors affecting expenditure growth. First are explicit factors that are known to directly affect expenditure growth: growth in the number of Medicare enrollees; allowed increases in physician payments; aging of the Medicare population; and the impact of legislative changes to the Medicare program. Second is the remainder, termed a "residual," which reflects all of the other factors which are not directly measured.

Projection and other errors must be considered in evaluating the extent to which excesses of actual expenditures over the MVPS are to be determined and subsequently reflected in the MEI update or the conversion factor. Historical divergences between actual physician payments under Medicare and their predicted levels have sometimes been quite large. Such forecasting error is inherent in projecting expenditure growth. For example, the Office of the Actuary of HHS has successfully prepared estimates of Part B outlays that are reliable for the long run, but at the same time cannot produce projections of year-to-year changes in Medicare physician expenditures that have the level of accuracy demanded by the intended use of the MVPS. Moreover, HHS and the PPRC have been unable to markedly refine their methodologies in the two and one-half years that the MVPS has been in effect. The resulting variations in MVPS expenditure projections underscore the need to set the MVPS as a range.

AMA Projection Method

There are a number of alternatives to the HHS/PPRC actuarial methods used to forecast Part B physician expenditure growth. Total expenditures for a year can be broken down into the following components:

- Changes in enrollment;
- Changes in the Medicare payment for each service; and
- Changes in the volume of services per enrollee.*

Using well documented measures of utilization responses to specific changes in the status of the Medicare beneficiary population, AMA research has shown that the average annual percent increase in Part B physician expenditures of 11.3% since 1985 can be fully explained. The resulting approach can therefore be used to predict future growth in Part B expenditures necessary to maintain appropriate beneficiary access.

Recognizing that all year-to-year forecasts are subject to a forecasting error, our comparison of forecasts from this approach with actual expenditures for several recent years indicates that the AMA forecast is accurate within 2.1 percentage points (plus or minus). For FY 92, we forecast that expenditure growth will be 10.3% (plus or minus 2.1%).

This forecast is only 0.4 percentage points higher than the HHS projection, based on the default MVPS formula, of 9.9%. It is 0.9% below 11.2%, what we understand to be the current HHS Actuaries' projection of 1992 expenditures. Although the forecasts are similar, the differing nature of the methods has clear implications for recourse to the HHS/PPRC approach of establishing the MVPS by arbitrarily reducing the unexplained residual of actuarial projections. Specifically, the access-based approach accounts for detailed economic and demographic changes that are elements of the "residual." It directly contradicts the HHS position that there is a lack of direct causal explanation for some 7.4 percentage points of the HHS projected increase. We believe this approach belies the HHS/PPRC justification for arbitrarily reducing the residual by as much as one-half.

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*This reflects the aging of the average enrollee, changes in real income, out-of-pocket costs per service, and effects of Medigap and other supplemental coverage.

The AMA, as part of our efforts to understand the components of the residual, has undertaken research to understand the contribution of technology to the growth of volume and intensity. A notable preliminary finding of this research is that consideration of services complementary to new technology could increase PPRC's estimate of the impact of technology volume growth for 1991 by as much as 42%. The AMA will continue to refine this research so that we can include a direct estimate of technology in future MVPS recommendations.

Because of the inescapable forecasting error inherent in all projection methodologies, and because of the demonstrated difficulty of reconciling forecasts with actual outcomes, the Association believes that the MVPS should recognize an acceptable range of expenditure increase (10.3% plus or minus 2.1% for 1992) rather than a single number, as HHS and PPRC have recommended. Congress should contemplate reducing the conversion factor update only if the actual expenditure increase exceeds this forecast range.

Conversion Factor Update

The 1992 conversion factor update should be set at the full MEI. This recommendation reflects the inherent imprecision in the 1990 MVPS, as well as the fact that this first MVPS was not issued until the second quarter of 1990, with little opportunity for physician education and without the quarterly progress reports required by statute. There should be no reduction due to the fact that the 1990 expenditures exceeded the 1990 MVPS by 1.5%, which is well within the expected error for the forecasts underlying the 1990 MVPS.

We believe that such an increase, based on the statutory measure of growth in physician practice costs (MEI) less 0.4% mandated by OBRA-90, is essential to maintain the resource base of the new physician payment system as it begins its first year.

Cost-Effectiveness and Cost Savings

Physicians recognize the need to constrain the rate of growth in Medicare expenditures. In this era of budget constraints, fundamental factors that directly affect the volume of health care services need to be addressed.

Our health care system is costly, and it continues to require more and more of our resources. Volume increases reflect several factors including -- new and expensive technology; aggregate population growth; more health-conscious consumers who utilize more services and technology; inflation; and the health problems associated with increasing societal problems. The AMA continues to address the volume and intensity of health care services through various measures that respond to many of these factors.

- Practice Parameters - The AMA supports measures that will enhance the value of every health care dollar spent. We believe that appropriately developed parameters, which will identify the medical consensus on the most effective treatment strategies for a given medical condition, will enhance the value of health care by helping to eliminate ineffective treatments and services.

- Technology Assessment and Outcomes Research - We support outcomes research and technology assessment to determine the effectiveness of medical treatments. The results of these assessments are communicated to practicing physicians and more than 1,150 health care organizations, primarily through AMA publications.

- Liability Reform - The AMA supports federal reform of the medical liability system. The estimated $20.7 billion attributable to defensive medicine and liability insurance premiums in 1989 is staggering. These costs contribute significantly to the access problem by causing physicians to abandon certain procedures and areas of the country.

- Patient Cost-Sharing - The AMA believes that patients, including Medicare beneficiaries, must be sensitized to the utilization of health resources through appropriate cost-sharing and limited favorable tax treatment of employer-provided coverage.

- Health Promotion - The AMA supports health promotion and preventive health measures. Society must be made aware of the severe and costly effects of lifestyle choices such as smoking, substance abuse, poor nutrition and lack of exercise.

- Rationalizing Health Expenditures - Society must continue to study the process by which it sets priorities for health care, with the ultimate goal not of limiting care per se, but of rationalizing our health care spending.

Conclusion

In conclusion, better knowledge of the underlying causes of volume growth is necessary to make informed decisions about the MVPS. Because volume and cost increases have multiple sources, the problems should be addressed with multiple responses, such as those we have suggested.

The AMA is dedicated to establishing valid, reliable information to be used in evaluating the components of Medicare expenditures, including elements of the residual--access, technology and unnecessary care. We know HHS and PPRC will continue their serious efforts to research this issue. This research is especially important if the factors driving volume increases can be understood so that policy makers can make informed decisions and physicians can develop appropriate responses to the true causes of volume growth that are within their control. Without such information, decisions will be made based on speculation and conjecture rather than on scientifically validated facts. We urge this Committee to continue its strong support for prompt results.

As you continue to examine the Medicare program, we also urge you to recognize the benefits to millions of people in need of medical and other health care. Actions aimed at artificially holding down legitimate program growth, especially with the major payment reforms now scheduled for implementation, may have unintended results and should not be taken without thoughtful deliberation and careful consideration of the consequences.

5975p

Table 1

**Comparison of FY 92 MVPS Recommendations**

| | AMA | HHS | PPRC |
|---|---|---|---|
| Enrollment | 1.4 | 1.3 | 1.3 |
| Average Payment per Service | | | |
| Full Update[a] | 3.1 | 1.6[c] | 1.6[c] |
| MVPS Recommendation[b] | 0.0 | -1.1 | -1.1 |
| Volume per Enrollee | | | |
| Aging | 0.1 | 0.1 | 0.1 |
| Other | 5.4 | 4.2[d] | 6.6[d] |
| Interactions | 0.3 | 0.1 | 0.1 |
| **FY 92 MVPS Recommendation** | **10.3** | **6.2** | **8.6** |

Note: All recommendations should be adjusted to account for legislation enacted this year and to reflect updated information with which projections can be improved.

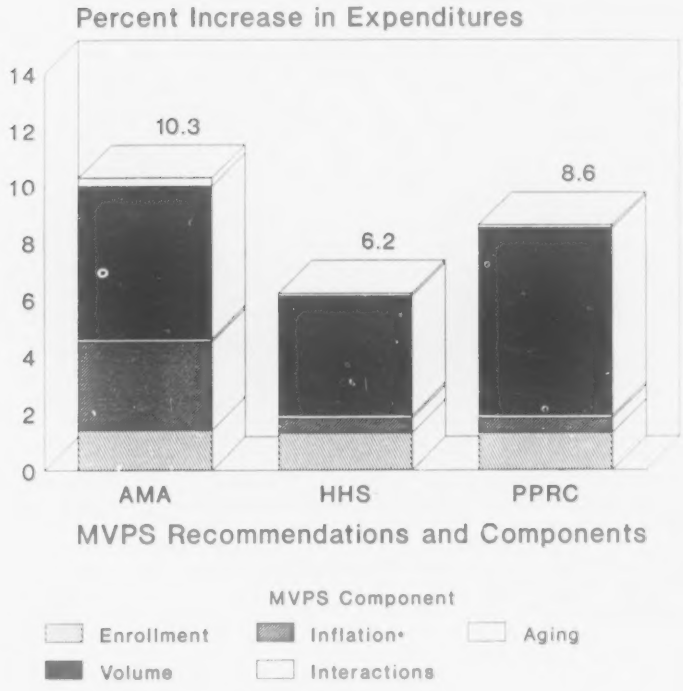
a All three recommendations reflect the fact that the calendar year 1992 update only affects three quarters of the fiscal year 1992 MVPS. The AMA projection of full update to FY92 is 0.4% higher than reflected in HHS and PPRC recommendations.

b HHS and PPRC recommend a reduction in the payment update in FY92 of 1.5% to reflect expenditures exceeding the FY90 MVPS. AMA recommends no such reduction.

c Includes 1.6% decrease associated with OBRA-90 effect as listed in HHS and PPRC recommendations.

d Includes 0.5% increase associated with OBRA-90 effect as listed in HHS and PPRC recommendations.

*Figure 1*
FY92 MVPS Recommendations
Comparison of Three Proposals




*Reflects MEI estimate, OBRA 90 payment cuts, and MVPS-related reductions. See Table 1 for a full explanation.

CENTER FOR HEALTH POLICY RESEARCH, MAY 1991

Chairman STARK. Thank you.

I would ask all three of our witnesses, although it was just Dr. Morris and Dr. Schenken who urge us to go with the full update, but assuming that the surgeon would receive it if we offered, I am going to tell you that this costs $150 million, and through no fault of the subcommittee's, we are on a pay-as-you-go system.

So, Dr. Morris and Dr. Schenken, where shall we take the $150 million out of the system to give it to the physicians? Do you each want to take a shot at that?

Dr. SCHENKEN. Well, Mr. Chairman, I don't think that the witnesses at the table were responsible either for the pay-as-you-go system——

Chairman STARK. I understand. I just want you to enjoy our dilemma.

Dr. SCHENKEN. I recognize your dilemma clearly, and it is a problem. However, I think the one thing that we need to emphasize is that the considerations in front of the committee have always been that the program is being funded by taxpayers' dollars and by premiums. Funding increases access because the doctors provide the service and they in some way impact control. However, there is a large number of factors that are important to the committee and the physicians having to do with utilization. We are talking about everything from seat belts to violence and to other things that those are going to impact on the services we provide.

Chairman STARK. Doctor, I understand that, but you are not answering the question. I have listened to Dr. Sullivan, too, but I don't know whether celibacy and abstinence and exercise sells any better in Omaha than it does in Oakland.

Dr. SCHENKEN. I doubt it.

Chairman STARK. I doubt it, too. I am willing to stipulate that alcohol and automobiles could go a long way toward reducing overutilization of Medical services. Nonetheless, I guess the point that I am trying to make is that if, in fact, we were to give you the full update, we would have to find $150 million next year in Medicare to cut.

Do you want to go back and talk to your hospitals and suggest that we—I don't know what that would take off market basket, but I am going to guess a point or so. Do you believe medical equipment should be targeted? That is about all they spend in a year.

We can't zero them out, although there are those who think we are trying to. I have just issued a press release to my friends, the Chicken Little's of the world, the Medicare trust fund people, who keep telling me that the trust fund is going to go broke. They said it would go broke in 1977. Then they said it was going to go broke in 1987. I think we have passed that. In 1978 they said it was going to go broke in 1990. In 1979 they said it was going to go broke next year. Their newest report says it is going to go broke in 2003. They keep pushing that little bar of soap ahead of us in the tub. The stark theory is if we cut 2 percent from market basket, it will never go broke. One percent will stretch it through at least 2011. But faced with that kind of pressure, the doom and gloom guys have to say Medicare is going to go broke, which then gives you the Jimmy Roosevelt's and the AARP's of the world.

I suggest that you haven't seen lobbying yet until you see that. Dr. Morris, where do I find the $150 million?

Dr. MORRIS. I would just suggest we go back to the idea of appropriateness of care. If we can devise a way to eliminate inappropriate care with practical standards that are usable, some savings can be realized.

Chairman STARK. I have a year now. You want this money this year, and I have got to save the money this year. It is not like—I agree with you that prospectively there are a lot of things we could do.

We could raise the taxes on cigarettes to $2 a package and make cigarette machines illegal within 500 miles of the closest public school or church. But in the real world of what this committee has to deal with, we come up short.

And I would say this without meaning to stir up trouble. We do have relatively well-paid physicians, and we have relatively high percentage increases. Although AMA may differ with our methodology, nonetheless we have over and above just the age, severity and population increases.

We have been using more services, and I think it is going to be very, very tough to go to the full update.

Dr. SCHENKEN. Mr. Chairman, I think, without speaking on behalf of the AMA at this point, I think doctors are citizens, too. The doctors that talk to me are as concerned about this deficit and these problems as you are. It is not as if we would be unwilling to look at the whole budget, if that was the job of the AMA.

We recognize it is. We have some serious problems.

Chairman STARK. Let me tell you what we did. I mean, preceding this, in fairness, I would be willing to bet you that more than half of the AMA membership are Republicans. Their subcommittee, with the help of my Republican colleagues, cut the Medicare budget one whole lot less than we were asked to by the administration.

If we had followed the administration's request last year, the full market basket wouldn't get you within 50 percent of being whole. I mean, I know that we don't get thanks when we cut something, but I am telling you this, if you don't like the fact that EKG's went down some, let me tell you how far they could have gone down. Or if you don't like the fact that overpriced procedures went down 15 percent, they were going to go down 30 percent.

So we had the battle of giving our share of the budget, and I think this committee, on a bipartisan basis, did a very good job of realistically meeting our responsibilities for pitching in to keep the deficit down.

But now you are talking about $150 million. I think this is beyond our reach. But let me say in all sincerity, if you could come up with an idea, let's hear it.

Dr. SCHENKEN. Mr. Chairman, I think that without getting into what I am registered to vote as, your comment was not lost on the medical profession. I think we observed it, and in many of the aspects of it we appreciated it without question.

On the other side of the coin, as you struggle with this problem, in spite of the perception that there are physicians that are

making a lot of money, there are physicians that are struggling and with a big debt coming out of medical school.

We do have to recognize we have problems with our rural physicians, our family physicians, our inner-city physicians, and with our young physicians coming out of medical school owing $50,000 to $100,000. Another branch of your committee chose to take away the tax deductibility of interest, therefore doubling the medical school cost every 7 to 8 years at current prices.

I am not saying yes or no. We recognize your problem, but there are also some specific problems we need your help with.

Chairman STARK. OK.

I guess I am saying, to keep driving that home, I would say that is great. We will go market basket. I have got to some up out of the system. I can't take it out of defense. I just went over to vote for burden-sharing. I think we lost.

Do I want to bring 8,000 more troops over from Korea? You bet. Do I want the Japanese to pay two or three times as much as they are paying us for defending themselves? You bet. You get me the votes, I will lead the charge.

You bring enough troops home from Europe and Japan and you get it all, but you have to get me the votes and get me reelected. Aside from that, sure, but you won't. We are going to lose.

Dr. SCHENKEN. Just don't close Strategic Air Command Headquarters in Omaha.

Chairman STARK. Let me ask you one other question about Omaha. Who is Bertram? I want to test your childhood reading habits.

Dr. SCHENKEN. I grew up in New Orleans.

Chairman STARK. You never read "Bertram and the Orange Orangutan," or "Bertram and the Purple Ant-Eater," or "Bertram and His Animal Friends?" You missed it. Bertram's father always went away to Omaha or business, and when he came home, he said, "Bertram, what did you do while I was gone?" The result was another Bertram book.

That is what I knew about Omaha when I was a little kid, Bertram's father went there on business.

One question to each of you, in trying to control the volume, whatever we are going to do, you are going to have to do it, not us. The committee tries to stay out of your practice. You may not think we stay out enough, but that is really the chair's goal.

What is your comment in working with HCFA over the past year or so? I will start with Dr. Ebert and go down the list. Do they cooperate with you? What could we do to help them be more cooperative because if you don't work with us, this is never going to happen.

How do you get along with them?

Dr. EBERT. I think we have had good input.

Chairman STARK. Or anyone else you deal with.

Dr. EBERT. I don't think we have had problems with them on definition of service. We don't have the global surgery package defined yet, so it is not possible to answer that part of the question. We have asked them to tell us what they are capable of doing as far as providing us with the most up-to-date data they can, because I believe that is essential if there is going to be any volume regula-

tion within the profession. I use that word "regulation" in quotations—but let's say "an attempt to influence behavior."

The data won't do much good if they come 2 years after the fact. I think it is going to have to be within the same year that one is trying to say, well, here are five locations in the United States that have increased surgical services 10 percent.

We are not a police organization, but we certainly would like to get the profession involved in defining whether or not such increases are appropriate or inappropriate.

Chairman STARK. Dr. Morris.

Dr. MORRIS. When I listened to Dr. Wilensky today, and this is my first trip to Washington for any sort of testimony, I was impressed. I would have to say that physicians are unfamiliar with most of the things she was telling you. I think out in the field HCFA has been bashed considerably.

The State of Georgia, with physicians' recent experience with Health Care Compare really upset everyone, but that was an individual case. Overall, I think we are pleased with her performance in HCFA.

Chairman STARK. Dr. Schenken.

Dr. SCHENKEN. Mr. Chairman, Dr. Wilensky has been absolutely cooperative, open, and available. There are things that are historically beyond her immediate control, such as data problems.

I think our biggest problem, as reflected by the previous speaker, has been with some of the regional offices, but the good news about that is we can take it to headquarters and get an open hearing. By and large I would say the cooperation is good.

Chairman STARK. My last question to each of you as a member of the panel, you may have heard me remonstrate, nag at Dr. Wilensky about data, and it is just absolutely appalling to me that we correct data. I don't care whether it is financial data or any kind of data in a variety of forms, and with no consistency. Really when you talk about getting data back to you, by the time the computer mavens get done fussing with it, 2 years have gone before they figure out how to translate it from one form to another.

Recognizing with me, if you would for a minute, that we may differ as to the idea of single payers or all payers, if you could be comfortable about whatever worries you may have about the Government's actions, would you find it convenient and helpful if we had basically a standardized billing form?

I know we could not enforce that on private insurers, but I have a hunch that if we enforced it through the Medicare system by way of a standardized computer software, we would make strides in getting these reports sooner and disseminating them to people. Does that cause you heartburn or might it simplify some of your procedures?

Mindful that I would have to give you the proper safeguards that I don't mean to bring along with other considerations that you might object to.

Dr. EBERT. I wish you could do it federally and for the private sector.

Chairman STARK. I think the private sector would follow.

Dr. EBERT. I would hope so.

Right now, the private sector seems to incorporate Medicare into its system, and a practicing surgeon dealing with a number of insurance carriers usually has half a dozen or so types of forms relating to the same age population in his office at any one time.

Dr. MORRIS. We could deliver more votes for you if you could do it.

Dr. SCHENKEN. With the caveats about single payer.

Chairman STARK. I know this sounds like a camel's nose.

Dr. SCHENKEN. We are strongly in favor of accurate data.

We led and developed the 1500 form. That was an AMA form which we had a hard time getting people to use.

The more uniformity we have, the easier for our doctors.

The data would be better.

Unless there is a glitch in the implementation, we would be right with you.

Chairman STARK. I hope that you will think about that.

Oftentimes—fault is a pretty useless concept. We are dealing with old data. It is slow. It is ponderous, and if these soldiers can stand out in the middle of the desert and locate Iraqi tanks with a lap-top computer and I can't find how many doctors are doing something in Omaha without writing 18 letters, we have a problem.

I am not saying we would treat doctors the same way we would treat Iraqi tanks—I can't help, but want to ask Dr. Schenken if the AMA endorsed the recent Journal of the American Medical Association's overall view and its presentation of the multiple options that are out there for working on the access problem?

Do you want to comment on that?

Has the AMA made a response to the Journal article?

Dr. MORRIS. The Journal is owned and operated by AMA, but has editorial independence.

The only article in there that is AMA policy is the article by Dr. Todd, which presents our views on Health Access America.

However, we believe the issues are important.

We were supportive of using that Journal to bring the issue to the public attention.

A large part of Health Access America is aimed at that.

On April 25 of this year, Dr. Todd appeared before the full committee to discuss this issue.

I hope that is responsive to your question.

Chairman STARK. It is.

As I say, it is, I think, a very enlightened approach. It sets at least a baseline for debate and I thought generously and objectively covered a broad spectrum of options and I was pleased to see that.

But I hope this debate can go forward on that basis, and it portends just a glimmer of hope for negotiation; that sometimes in the past I don't think has been there.

But it was a good article and a good issue.

I was glad to see it.

Mrs. Johnson.

Mrs. JOHNSON. I also was glad to see it.

Chairman STARK. You got mentioned in it, that is why.

Mrs. JOHNSON. I was even more glad to hear that.

There is not a lot that the chairman and I agree on, but I do agree on the single form issue. We ought to be able to do some of those things without having to come to a global understanding of our problems and their solutions.

Dr. Lee and Dr. Wilensky were very specific in their descriptions of how volume caps can be met and how this new fee structure should affect the volume of services that physicians provide.

A, have you done any analyses to see how many of your physicians even know that there is a new fee structure next year?

B, what preparations have they made to change their behavior to reflect the change in public policy?

And C, what is your best guess as to the outcome?

Any of you may respond.

Dr. EBERT. Well, for the surgery side, I would say since the fee schedule is not yet published, but is anxiously anticipated, and since there are issues related to geographic costs of practice that are going to be factored into that, that some will be happy and some unhappy, if original projections are correct.

Many people in rural America probably will be happy. I know they know it is coming. I don't think anyone as yet has a real interpretation of what impact it may have on specific operations in specific locations, because the information just isn't there.

Mrs. JOHNSON. They know it is coming. Are any of the societies throughout America thinking through how to reduce volume since payment now depends on it? A rational payment system that is going to be good for us next year and the year after depends on our finding a way to reduce volume, but we aren't structured to reduce volume.

Normally in the private sector if a company knew that the market was going to change a product, they would make plans to accommodate that change whether it meant reducing the cost of production or finding something else to sell.

Are your societies making any concrete plans with their membership to try to change behavior?

Dr. EBERT. From the surgery side, you have to recognize the anticipation is probably that there will be a reduced price per operation. I don't see that, at the same time, there is much worthwhile in spending a lot of money to figure out how to further reduce the volume of services provided by a group that is already being paid less for their services.

We have spent a lot of time in data collection over the past decade showing that there isn't that much increase in the volume of services. Cataract operations go up when a new advance comes, but they go back down again when another alternative treatment comes. We are more concerned that behavior may be in the opposite direction, that if I have a decreased price per item, I might figure I ought to do more of it.

We don't think that is as likely in surgery as in areas where the patient is more willing to have a particular test performed. We are more concerned with how we are going to adjust in order to regulate the volume in the profession if we do see an increase, than to say how we are going to decrease it.

We are going to get no rewards. We don't believe in an MVPS for reducing price and thus volume in surgery because our cost re-

duction has already occurred in the price per operation. We will have difficulty if the volume goes up in areas for which there is no justification. That is where our emphasis is, the appropriateness, inappropriateness, and regionalization of operations, and that is where we need the feedback data.

Dr. MORRIS. The college, since the late 1970's, has been involved in a Clinical Efficacy Assessment Project in which they have evaluated various diagnostic procedures and technologies to determine whether they are valuable.

That has been written up in policy statements. Some of the original ones, such as gastric freezing, were eliminated early. The early ones were easy to evaluate because they dealt with procedures and technologies that were outdated and poor.

The later ones were harder to develop because the scientific data that forms the basis of these types of studies is difficult to attain. It takes much more money than the college has been able to put into it.

From a personal standpoint, if I went to our hospital staff and said: Tell me what you know about MVPS as an acronym. Fifty percent would say: What? Another 50 percent would say: I think I know what that is. Maybe half of that group would know somewhat what it is about.

If you ask: What is the RBRVS? They would all know that. So they are all wired into the resource base relative value scale and anticipate the changes from that. But I don't think they have been affected yet by the volume importance standards.

Until there is experience as end users, I don't think they will appreciate its importance.

Mrs. JOHNSON. The irony is that unless the behavior responds to the incentives in advance, payments go down next year and then the message is do more. We see this in price support systems. One of the problems we have in the farm program is that we cut the price supports for milk and those farmers who were able, milked more.

We end up in a spiral that leads to catastrophe. In this case that spiral leads to lower and lower reimbursement and physicians doing more and more volume until finally they stop taking Medicare patients. This is what happened in Medicaid.

The organizations of physicians must begin educating their members about the intersection between the relative value scale change and the new fee scale and what it does with volume. They must discuss "how are we in our area going to look at patterns of practice so we can reduce volume?" I know it is formidable, but if the associations aren't going to do this, then, frankly, the consequences of our policy are going to be very much more similar to the consequences of our policy in Medicaid than they are to anything resembling any other nation's health care system that any member might claim to admire periodically.

Dr. SHAPIRO. If I might address that for a moment, Mrs. Johnson, you have mentioned the idea of profiling. I think that is an extremely important change, an advance that will be required to change physician behavior.

Partly in answer to your question, Mr. Stark, about relationships with HCFA, Dr. Wilensky said that the scope of work for the

PRO's is being changed to move away from retroactive case-by-case review to profiling physician behavior.

Once the physician organizations begin to get that data on the individual level, it won't take much in terms of peer review and support and education to shift physician behavior, because it seems to be the experience that physicians want to practice in the norm.

Mrs. JOHNSON. We are a couple of years out of synch. What she is doing in the PRO's won't produce things physicians can use for 1 or 2 years. Likewise, with the guidelines initiative, it is coming along but it is not quite there and it is not broadly disseminated. In some areas—my husband is a physician and that is how I happen to know this—there is a lot of community profiling, and it has made a tremendous difference.

I don't think it has compromised quality, but I believe it has reduced costs. You can do that professionally. You've got to hook the stuff that is possible—and that is sometimes happening—into this shift in public policy with regard to reimbursement if we are not going to head down the road we headed down in Medicaid.

We can avoid that road if you can give us a hand this year and the signs will catch up with us, and hopefully in the outyears give us more help in more rational control of volume and therefore prevent the system from spiraling out of control.

This first year it is extremely important for you to use your resources within your organization to do as much local information-sharing as you possibly can.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman and thank you, gentlemen, for your testimony.

I am still on this evolution of practice kick in terms of technology and its assessment. As I look at the table provided to us by the Physician Payment Review Commission, I see an example; maybe it is an isolated case.

This is for you, Doctor. Orthoscopic surgery's volume is up. Its outlays are up, but isn't that the way to go now in surgery on joints as opposed to opening up a knee like I had to have done?

Dr. EBERT. No, I think that is right. When you have a technological advancement that involves less morbidity, minimal mortality, and less discomfort to the patient, more patients wish to have it performed.

I bet it will be similar to the experience with cataract operations and some of the other rapid advances. You will see a rapid rise in the number of operations and then a tailing off as the backlog of patients are treated—there will be a stability coming.

Mr. MCGRATH. You only have one gall bladder. You have two knees and the opportunity to have more than one orthoscopic operation even on one knee is not extremely rare. Let me ask you this. I know how vociferously the physician community fought expenditure targets when they were enacted, and the reason was that it was going to eventually affect the quality of care.

We are now only a year down the line. Do you still feel that way? Does it still matter, or do you think that this thing has a possibility of achieving its goal without affecting the quality of care too much?

Dr. SCHENKEN. Mr. McGrath, we do not feel that the Medicare volume performance standards are the same as ET's. ET's were arbitrary and were going to happen with no evaluation. The MVPS has built in a study of many things, including access and quality. Granted, it is fairly subjective at this time.

Mr. MCGRATH. But its application is the same?

Dr. SCHENKEN. It may or may not be, depending on the committee and the Congress. We continue to be concerned that the final MVPS decision will be made purely on the basis of dollars and the technology advances. Some of which are important, some of which are not. There is a possibility of arbitrarily restricting access to new and evolving services.

That is one reason that the AMA is supportive of the MVPS. Everybody can study this as it goes along and make sure that if we are going to restrict services, it will be based as much as we can on Medical indications. I expect that is what the committee would like, as well.

Dr. MORRIS. I would think the college stand would be that if the decline is gradual, it would have no impact on quality of care, but if the decline is abrupt, it might, particularly in areas of general internal medicine.

This is a group where cost of providing care to Medicare patients is reaching a point where the Medicare payment might fall within a few years. When that happens, you are subsidizing Medicare patients resulting in internal medicine specialists saying it would be difficult to see any more new Medicare patients or trying to dump some of those patients.

Mr. MCGRATH. How realistic is that?

In Wyoming County, NY, if a doctor there didn't see a Medicare patient, nobody would be seen. In my district, where 80 percent of their practice is Medicare, if somebody doesn't see a Medicare patient, somebody else is there to pick up him or her.

That seems fairly subjective based on the area of the country where you live. I haven't supported, up to this particular point in time, any kind of assignment not based on my own district. In my district, these guys would go broke if they didn't see Medicare patients, and hospitals would be the same way.

Most of the hospitals in my district have occupancy rates of 95 percent, and 75 percent of those are Medicare patients.

I am concerned that all of these things in the aggregate do not affect the quality of care. I want you guys to tell us when you think they are starting to.

We can either accept or reject your recommendation at that particular time, but I would say put that red flag up. Now, if you put it up too often, we are not going to listen to you. Thank you.

Chairman STARK. Well, I want to thank all of you. As I tried to illustrate at the beginning of my query, it is a touchy project for us.

We cannot do it without your cooperation, and I am sure the committee is aware that there will be winners and losers in this. However, to the extent we can, we will try to find a good way to go about it. But one of the things that occurs to me, there seems to be this idea that a particular procedure will get an increased payment

or not, and I just think this is anecdotal, but you have heard us talk earlier today about MRI's.

I am aware of one recent back surgery and somebody else who is a candidate, but largely is inoperable at this point. But in both cases, going through perhaps starting with a GP and then moving on to some other specialist, I found that one person in a period of 30 days got three MRI's because he saw three physicians.

I was under the impression at the end of that time that you couldn't reuse them, that you had to be there. It didn't make any sense. I finally suggested to this person to carry it when he went to the doctor.

I have a hunch that this is inadvertently wasteful. Maybe it is convenient for the physician involved and I understand when they say the first radiologist, I want to make sure that my radiologist does it right, but I figure you guys must have as much confidence in licensing boards as you expect us to have.

How do you stop it? For us to start passing laws restricting the allowable number of MRI's in a given time period would not make any sense. Furthermore, we have no desire to do it, either. The question is, how do we get doctors to see we are going to be a little parsimonious with the number of tests?

I don't think you can blame it all on malpractice. Some of it is defensive. But I think that is often an excuse rather than a real necessity. I would like to suggest that. I have a hunch there are a lot of things out there where we could get the other people to cooperate but I don't know how to force it.

Bundling may force it. I don't think that is very popular. It may work some, but if you all would come up with an idea it would be better than if we were to come up with the idea. I think we are going to do it because we have to. We just don't have the money and you will not allow me to preside over a committee that has a budget bigger than the Defense Department, as powerful as that would make us. Sooner or later the physicians would wake up and say that is a bigger danger.

Thank you for working with us. We look forward to working with you as we plan this year's budget and budgets to come.

Thank you.

[Whereupon, at 4:20 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
HEARING ON THE MEDICARE VOLUME PERFORMANCE STANDARD SYSTEM,
THE PHYSICIAN UPDATE FOR 1992,
AND INCREASES IN THE VOLUME OF MEDICARE SERVICES
MAY 21, 1991

Thank you for the opportunity to present the Subcommittee with the views of the American College of Cardiology (ACC), an 18,700 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy. We welcome the chance to provide input to the development of a 1992 Medicare Volume Performance Standard (MVPS) as cardiovascular medicine represents a substantial and critical component of the health care system, particularly for the Medicare population.

This statement outlines our initial assessment of the key elements of cardiovascular medicine that relate to the volume of services provided to Medicare beneficiaries. The following discussion focuses on emerging and existing technologies and procedures, including therapeutic and diagnostic services, as well as services that seem likely to decline in use or be replaced.

Congress should continue to expect and support a substantial increase in the volume of cardiovascular services. This growth is attributable to a number of factors which include (without prioritization): advances in medical technology; demographic trends in the U.S. population; trends in the supply of cardiovascular specialists; cost-containment initiatives leading to a shift from inpatient to outpatient diagnosis and therapy; increased income and sophistication of the elderly resulting in a greater demand by this group for physician services; increasing acceptance of Medicare assignment rates; and survival of a growing portion of our citizens with cardiovascular disease because of advances in cardiovascular diagnosis and treatment. These developments are strongly interrelated, and the list is not considered exhaustive. The following will provide our best initial judgement on issues and developments related to the delivery of cardiovascular services.

## I. GENERAL BACKGROUND

### A. Incidence/Prevalence

The American Heart Association has estimated that 68 million Americans suffer from at least one form of cardiovascular disease, including coronary heart disease, stroke and hypertension. Of these 68 million, approximately 18 million are over the age of 65 years (more than 56 percent of the Medicare population).

While more than 50 percent of all heart attacks occur in those 65 years of age or older, it is estimated that in 1987, over 80 percent of those who died of cardiovascular disease were over 65 years of age. The leading cause of morbidity and mortality in the elderly is coronary heart disease manifested by coronary artery atherosclerosis leading to inadequate blood flow to the heart muscle (coronary ischemia).

The evidence is clear, however, that advances in cardiovascular health care have had a positive impact on the incidence of heart disease. The Department of Health and Human Services report "Health, U.S., 1989" points out that the age-adjusted prevalence rates for heart disease have decreased by 33 percent between 1980 and 1987. Between 1978 and 1988, the death rates from heart attack and high blood pressure have declined 29.2 and 20.2 percent respectively.

### B. Technological Advances

Technological advances now permit an increasingly aggressive approach to coronary heart disease in a broader group of patients. In many cases, the physician has the opportunity to quickly and directly restore blood flow to the heart muscle, often with a less invasive approach, providing both relief and prolongation of a productive life.

These advances (therapeutic as well as diagnostic) have contributed profoundly to the decline in morbidity and mortality rates for

cardiovascular disease. They also contribute to growth in volume and expenditures for certain cardiovascular services. For example, surgical revascularization can now be accomplished in the elderly with a risk/benefit ratio similar to that in much younger patients. On the other hand, new technologies and treatments decrease the need for hospitalization and shorten the length of stay for such diagnoses as acute myocardial infarction and congestive heart failure. These can be seen as cost-effective and quality of life benefits.

### C. Prevention and Early Diagnosis

We may be able to decrease, to some degree, dependence on more expensive "end stage therapies" for our patients by effectively dealing with the disease process through prevention and early diagnosis. A variety of measures, such as new drug therapies and approaches to myocardial imaging and revascularization, may prevent costly hospitalizations and/or reduce lengths of stay. As non-operative revascularization procedures improve with new technologies such as laser angioplasty, atherectomy and endovascular stents, dependence on operative revascularization may, for certain populations, decrease.

It is clear, therefore, that unless the American public agrees to ration expensive health care based on age, an unlikely prospect, the volume of services and health care costs for the elderly will continue to increase. The challenge is to spend existing resources wisely and in such a manner that best addresses the well being of Medicare beneficiaries.

## II. TECHNOLOGIES AND PROCEDURES

We believe the most likely advances will be in the management of coronary heart disease in its various stages. Historically, the cardiologist has been a specialist in the diagnosis and medical treatment of cardiovascular diseases. With the development of catheterization techniques and angiography, the cardiologist has become increasingly "invasive," embracing a variety of non-surgical approaches to the opening of "clogged" arteries, including thrombolytic (clot dissolving) therapy. Consequently, the treatment of acute coronary syndromes (acute myocardial infarction and unstable angina pectoris) has become much more aggressive and successful.

### A. Therapy: New/Emerging

Recent scientific discoveries have shown that acute coronary syndromes involving clogged arteries can be relieved if the flow of blood can be restored/improved. Restoration of blood flow may be accomplished with thrombolytic drugs, catheter techniques, or coronary artery bypass surgery. However, intervention must be immediate if heart muscle is to be saved and this often requires emergency transportation of the patient and acute cardiac catheterization. These techniques increase the potential for successful restoration of blood flow in patients who previously would have suffered irreversible heart damage.

#### 1. Thrombolysis

Coronary thrombolysis (use of a chemical agent to dissolve a blood clot) has been shown to reduce mortality and preserve heart muscle following acute myocardial infarction compared to conventional management of patients treated promptly after the onset of chest pain.[1] [2] [3] Successful coronary thrombolysis may then lead to further diagnostic testing to ascertain the extent of residual coronary atherosclerosis and myocardium in jeopardy.

A recent clinical trial demonstrated that research can provide guidance not only on efficacy and outcomes, but also on the relative costs of therapy as well. The results of ISIS III show that an inexpensive thrombolytic drug such as streptokinase is as efficacious as more expensive agents such as tissue plasminogen activator (commonly known as t-PA)[4]. Thus, the potential exists for reduced spending for thrombolytic therapy.

On the other hand, the use of thrombolytics may not be at its optimal level in the United States. One study found that use of thrombolytics in the United States is significantly lower than in European

countries. As noted above, an increase in the use of thrombolytics is likely to be associated with an increase in coronary angiography procedures as well.

**2. Catheter Revascularization Procedures**

a. Percutaneous Transluminal Coronary Angioplasty (PTCA) is a minimally invasive technique using catheterization technology to restore or enhance myocardial blood flow in partially or totally blocked coronary arteries. Although standards and indications have been established, these may change as new information is developed from ongoing comparisons under a variety of circumstances with medical treatment and with surgical revascularization.[5 6 7 8 9 10]

PTCA is now in its twelfth year of use, and guidelines have recently been developed jointly and published by the American College of Cardiology and the American Heart Association. The use of this procedure is beginning to stabilize in patients with multivessel disease where comparison of PTCA vs. coronary bypass surgery is under study, and in post-infarction patients where early PTCA after thrombolysis has not proven advantageous.

Overall, however, it is anticipated that the use of PTCA will increase over the next decade. Several factors contribute to this projection, including improvement in catheterization equipment and an aging population developing new disease. In addition, increasing numbers of post-bypass patients with new disease in bypass grafts circulation may be helped by balloon angioplasty rather then repeat surgery.

Furthermore, the problem of re-stenosis, i.e., recurring blockage in the same location, means that more people will require repeat angioplasty. Even if techniques to prevent re-stenosis that are currently under study prove effective (e.g., "stents" and prevention of the hyper-reaction of the arterial wall to injury), the frequency of use of PTCA could still increase.

b. Emerging from the technique of balloon dilatations are several new technologies descriptively called atherectomy catheters, rotoblator catheters, laser catheters, and intravascular ultrasound, all directed toward the removal of intra-arterial atherosclerotic blockage. These techniques have the potential to fundamentally change the way in which non-surgical revascularization is accomplished.

If one or more of these techniques proves useful, there will be an increasing volume of these services for the first 5-6 years after introduction. It is unclear whether these procedures may in some cases replace balloon angioplasty. In fact, some of these may be used to augment the success of balloon catheters. Within 6 to 10 years their clinical potential and cost effectiveness will be more fully understood.

**3. Management of Arrhythmias and Sudden Death**

Although the incidence of cardiovascular deaths has decreased dramatically over the past 20 years, the incidence of sudden death has not declined at all. In most cases, sudden death is the result of ventricular arrhythmias in association with a variety of cardiovascular diseases, most commonly with coronary artery disease and/or congestive heart failure.

Candidates in this clinical situation can often be identified by cardiac electrophysiologic studies, and treated appropriately by drug therapy, implantation of an implantable cardioverter defibrillator (ICD), or cardiac surgery. Technology is now available for using cardiac catheters to actually eliminate pathological heart rhythms (percutaneous ablation of arrhythmic foci) in the heart and will be increasingly utilized. ICDs have a demonstrated favorable clinical experience and the technology has been continually improved, most likely bringing greater utilization. In sum, small but significant increases in all of these services can be expected.

**4. Cardiac Transplantation and Artificial Heart**

Heart transplantation is no longer a front page media event. Scientific progress has moved transplantation from the realm of the experimental to the reality of the practical. The very favorable results of cardiac transplantation now being achieved in many centers will lead to increasing application, limited only by the availability of donor hearts. This remains a form of therapy for end-stage heart disease.

The totally implantable artificial heart is still a dream, but one that may become a reality. Furthermore, the temporary, explantable ventricular assist device which provides support for a patient until a donor heart can be obtained for transplantation will be increasingly utilized, though not widespread.

**5. Drug Therapy**

Surgical techniques for saving the lives of cardiovascular patients receive most of the headlines, but over the past 25 years the pharmaceutical industry has provided the medical profession with a remarkable array of drugs to treat hypertension, coronary heart disease, and congestive heart failure. These drugs include household names such as "beta blockers," "calcium channel blockers," and "ACE" inhibitors, all contributing to a continuing decline in the death rate from cardiovascular disease.

New drugs in these established classes as well as new classes of drugs are being developed. Among the latter are thrombolytic agents currently in the news (e.g., t-PA, streptokinase) and discussed in A.1 above; monoclonal antibodies for the treatment of a variety of cardiovascular diseases and the rejection phenomena of cardiac transplantation; drugs to inhibit re-stenosis after PTCA; and oral inotropic agents to strengthen the heart muscle in patients with congestive heart failure. Lipid lowering drugs will also increase in use.

A major direction of research in cardiovascular disease is in understanding molecular biology in the heart and blood vessels. One result of this area of scientific inquiry has been the introduction of drugs modifying the metabolism of body lipids so that atherosclerosis may be less likely to develop. If the secrets of atherosclerosis can be discovered and treated, marked reduction in the use of costly, high technology procedures, now employed to revascularize the heart and peripheral organs, will occur. However, preventive treatments can also result in a greater pool of patients with cardiovascular disease who need to be monitored.

**B. Diagnostic Procedures: New/Emerging**

A variety of new technologies designed to screen, functionally evaluate, and diagnose cardiovascular disease in patients are being developed. Of greatest significance are non-invasive imaging techniques which may be widely applied to all types of patients because of lack of risk or patient discomfort. Information is obtained pertaining to cardiac anatomy, function, and prognosis previously unavailable or available only by invasive procedures.

Screening efforts and preventive education should increase and include physician evaluation, detection and treatment of hypertension, hyperlipidemia, and diabetes mellitus, as well as smoking cessation and exercise instruction. Indeed, President Bush's FY92 budget estimates that 45% of cardiovascular-related deaths could be prevented through changes in behavior and early detection and intervention.

Most prominent among the non-invasive cardiovascular diagnostic techniques are: 1) ultrasound; 2) radionuclide imaging; 3) magnetic resonance imaging; 4) signal averaged electrocardiograms; and, 5) high speed computed tomography.

**1. Ultrasound Imaging Techniques - - Echocardiography**

Cardiac ultrasound is an excellent example of how technology has evolved from a relatively simple application to one of the most

valuable--and inexpensive--of our diagnostic tools. It rivals physical examinations, x-rays and electrocardiograms (ECG) in importance and usefulness.

Cardiac ultrasound evolved from a uni-dimensional to a two-dimensional technique to evaluate normal and abnormal cardiac anatomy and function. An increasing interest in non-invasive outpatient testing will lead, we believe, to an continued expansion of the general use of echocardiography, and more specifically two-dimensional and Doppler echocardiography.

Doppler ultrasound permits evaluation of direction and velocity of blood flow within the heart and blood vessels and quantification of intra-cardiac pressures. The new color flow Doppler provides direct visualization of blood flow by color conversion. Doppler echo is becoming the method of choice for evaluating native and prosthetic heart valves and has nearly eliminated the need to catheterize patients with valvular disease unless a need to examine the coronary arteries exists.
More recently, ultrasound via a transesophageal catheter provides spectacular views of the heart and heart valves from within the esophagus. This technique has vastly improved the cardiac surgeon's ability to perform and evaluate cardiac valve replacement in the operating room and the cardiologist's ability to provide care for these individuals who have required prosthetic heart valves. Its use has also continued to increase in the management of cardiac patients undergoing non-cardiac general surgery.

The use of an intravascular ultrasound catheter, used first to diagnose and then to unclog arterial blockages, is becoming more widespread and will continue to increase in volume. Ultrasound catheterization is expected to be approved for an appropriate application, perhaps with atherectomy technologies.

Finally, we recognize that the advances in the treatment of congenital heart disease have resulted in a larger population of adults with congenital heart disease. Echocardiography is needed for their continued diagnosis and care. The volume of echocardiography services, including imaging, continuous wave Doppler and color flow mapping procedures is expected to increase.

Intensified interest in coronary artery disease and outpatient testing could cause stress echocardiography to increase at a rate greater than general echocardiography. Stress echocardiography seems to be replacing stress nuclear studies in office settings. The availability of pharmacologic agents to induce stress has increased the patient pool which can be studied in a technically acceptable fashion.

**2. Radionuclide Imaging**

Radionuclide studies may provide information on: size and the global and regional function of heart muscle; areas with reduced blood flow, typically during exercise imaging; and viability of myocardium.

**a.** The area of radionuclide imaging that continues to possess the most useful clinical information is that of perfusion imaging, for example, SPECT (single photon emission computed tomography). Providing a major advantage over planar thallium imaging, it provides a three dimensional rather than two dimensional image. Improvement in gamma camera technology and newer isotopes (technetium-99m) will create a steady growth in volume. Furthermore, there is evidence that thallium SPECT imaging permits evaluation of muscle viability as effectively as PET imaging. The use of SPECT for this purpose will increase.

**b.** PET scanning (positron emission tomography) is presently limited by the numbers of centers performing this procedure. PET effectively assesses the viability of heart muscle and has some potential to provide better information than that gleaned from conventional radionuclide studies. Due to the significant start-up costs of PET, a slow rate of increase is anticipated.

**3. Magnetic Resonance Imaging (MRI) and Spectroscopy (MRS)**

Technologies that may expand into cardiovascular medicine over the next few years are MRI and MRS. These non-invasive and non-ionizing procedures provide high resolution visualization of the heart and great vessels and, potentially, of smaller blood vessels. The development of appropriate computer software and hardware could mean even greater use of these procedures in the practice of cardiovascular medicine.

Nuclear magnetic resonance imaging also has the potential for increased application due to the development of myocardial tagging. This technology enables the same area of myocardium to be studied throughout the cardiac cycle, and therefore, eliminates the confounding variables of rotation and translation in the evaluation of regional contractile pattern.

Myocardial scanning can determine if further therapeutic intervention is necessary by assessing if a region receiving less blood is viable. Effective use of myocardial imaging may ensure that PTCA and CABG are performed more appropriately.

**4. Signal Averaged Electrocardiograms**

The use of signal averaged late potentials in risk stratification of patients suspected of malignant ventricular arrhythmias and following acute myocardial infarction is growing. It is expected that this technology will be incorporated with the present ECG data acquisition carts which are now being offered in conjunction with computerized electrocardiographic interpretation and management technologies.

**5. High Speed Computed Tomography**

The use of high speed computed tomography ("fast CT") scanning to assess coronary calcification in those with coronary artery disease could increase dramatically in the future.

**C. Therapy: Existing Technology**

**1. Coronary Artery Bypass Graft Surgery (CABG)**

Coronary artery bypass surgery will increase in volume in the next few years despite alternate therapies for several reasons: a) aging population; b) improved arterial conduits (internal mammary and internal thoracic arteries); c) proven efficacy in long term survival and relief of symptoms resulting in increased productivity; and d) complexity of coronary disease in some patients making them ineligible for alternative therapy.

CABG surgery has been extensively studied and has been shown to provide symptomatic relief superior to medical treatment, and prolongation of life irrespective of symptoms in certain patients with coronary disease, e.g., left main coronary stenosis, triple vessel disease with good or impaired left ventricular function. [11 12 13]

**2. Peripheral Vascular Surgery**

Indications for peripheral vascular surgery are well established. Although angioplasty procedures for peripheral vascular disease are increasingly utilized, re-stenosis remains a problem. Surgical intervention remains a viable option. We expect that the volume of these services will increase.

**3. Valve Surgery**

Improvements in the surgical management of the elderly patient in terms of improved anesthetic management, better myocardial protection, refinements in postoperative care and the development of reliable prosthetic valves have led to an increase in aortic valve replacement. The most common indication for aortic valve replacement in this country is calcific aortic stenosis in which the valve leaflets become progressively calcified and inflexible, a condition associated with aging. Therefore, the volume of valve surgery is expected to increase.

**4. Pacemaker Implantation (Permanent)**

A marked reduction in the volume of pacemaker implants occurred after the cardiology community provided guidelines for appropriate use and HCFA implemented a prior authorization program. More technologically sophisticated devices are now being employed to be responsive to a patient's activity level (dual chamber, activity activated). The volume of pacemaker implementation could therefore slowly increase.

**5. Carotid Artery Surgery**

Results recently published by the NIH show that carotid endarterectomy provides a substantial benefit in reducing the rate of stroke. Volume has the potential to increase.

**D. Diagnostic - Existing Technology**

**1. Electrocardiogram (ECG)**

The ECG remains an extremely important test for evaluation of patients with suspected or proven cardiac disease. It provides the only technique for diagnosing and monitoring disturbances of the heart rhythm in a simple fashion at the bedside, in the operating room, or other settings. The resting electrocardiogram has been documented to provide important prognostic information in patients with coronary artery disease and provides decisive information for clinical management in many other settings. Recognition of the importance of the ECG in the training of cardiologists is reflected in a decision by the Cardiovascular Subspecialty Board to define a core set of electrocardiograms that must be correctly interpreted as a requirement for Board certification.

**2. Ambulatory Electrocardiography (ECG)**

Advances in our knowledge of cardiac arrhythmias have established the benefit of ambulatory ECG, and guidelines for its use have recently been developed by the American College of Cardiology and the American Heart Association. Ambulatory ECG is primarily useful in the diagnosis of arrhythmias, the determination of effectiveness of therapeutic interventions, and, more recently, in the evaluation and detection of silent coronary ischemia. Technological developments providing more focused monitoring and improved electronics may result in a substantial increase in volume of ambulatory ECG services, including event recording and transtelephonic electrocardiograms.

We estimate, however, that there could be a 5-10% decrease in the use of Holter monitoring in the next 2-3 years. Patients with life threatening ventricular tachyarrhythmias are much more frequently evaluated by electrophysiologic studies in the hospital. Indeed, the marked increase in percentage (increase of 241 percent) of EP studies reflected in existing BMAD data is consistent with the decrease in the use of ambulatory monitoring. We believe this trend will continue.

**3. Cardiac Ultrasound - Echocardiography**

Two-dimensional and Doppler echocardiography have previously been discussed. Both remain mainstays of diagnostic cardiology. Exercise echo is a suitable method for exercise testing but because it is technically demanding to perform, it is used relatively infrequently.

The volume of echocardiography services can be expected to grow as more physicians are trained in this technology.

**4. Stress Testing**

Established guidelines developed jointly by the American College of Cardiology and American Heart Association now state that an exercise test is indicated in most patients with suspicion of coronary ischemia before a heart attack, and in others after a heart attack, CABG or PTCA. This technology has added a new dimension to evaluation of a patient's risk for acute myocardial injury.

Thallium perfusion scans and exercise echo studies add to the sensitivity and specificity of information obtained. In addition, pharmacologic agents which induce an "exercise response" state can be used for patients who cannot undergo actual exercise. The volume of

all types of stress tests are expected to increase.

**5. Electrophysiological Studies (EPs)**

As noted in A.3) above, EP studies are being used to identify those at risk for sudden cardiac death. Volume is expected to increase.

**6. Cardiac Catheterization and Angiography**

These technologies are well established and guidelines have recently been published by American College of Cardiology and the American Heart Association. Catheterizations and angiography provide definitive information in certain circumstances where the information is unavailable from any other source. Volumes of these procedures will increase in the future, especially if stand alone and mobile catheterization laboratories are allowed to proliferate.

In addition, diagnostic catheterizations will continue to increase given the mechanical options for opening up plugged grafts and vessels other than surgery. Thus, whereas a diagnostic catheterization was avoided in an inoperable patient in the past, now diagnostic catheterizations are done to determine which mechanical option is appropriate. This is true for many elderly people and others who would be inoperable because of associated diseases. Thus, the need for diagnostic coronary angiography will continue to increase markedly.

**7. Myocardial Biopsy**

This is essential for follow-up of cardiac transplant patients. It is also recommended for patients with an unexplained cardio-myopathy. The volume of these services will increase.

**E. Therapy: Outmoded or Declining Technology**

1. Aortic valvuloplasty will decline over the next 4-5 years. It appears to offer transient, poorly-sustained clinical improvement in an end-stage disease process.

2. Mitral valvuloplasty has proven beneficial, and volume is expected to remain stable over the next 4-5 years at a low number in very selected patients.

3. The use of angioscopy as an adjunct to catheterization techniques has proven most useful in the study of the pathogenesis of arterial thrombus formation and assessing the nature of atherosclerosis by direct visualization of these processes from within the vessel itself. The procedure has limited applicability at present and some speculate that rapid diffusion into clinical practice is unlikely.

**F. Diagnostic Technology: Declining or Outmoded**

1. The following are not generally used as clinical tools but are useful in a teaching situation:

   a. systolic time intervals
   b. phonocardiography
   c. apex cardiography
   d. vector cardiography

2. M-Mode echo is not a stand alone procedure anymore. It is always (if done at all) a part of a 2-dimensional echo study.

3. Right heart catheterization with or without insertion of a temporary pacemaker catheter during diagnostic catheterizations will decline for most patients with coronary artery disease. However, there may be unique circumstances in an individual patient where one or the other or both are required.

## III. LEVELS OF CARE

The recent emphasis on outpatient care has led to more complicated case management as well as more severely ill patients being admitted to the hospital. This results in an appropriate increase in the numbers and

intensity of hospital visits, consultations and critical care visits. Because patients, and particularly older patients, are sicker and often affected by more complex multiple disease processes, there has been an appropriate increase in follow-up consultations and more extensive subsequent care visits by a cardiologist as these patients undergo non-cardiac procedures. Ideally, we would anticipate more widespread access to preventive services, potentially reducing the need for the more complex and expensive care.

## IV. SUMMARY

The substantial increase in the volume of cardiovascular services is explained in part by an aggressive approach to ischemic heart disease related to coronary atherosclerosis. Ischemic heart disease, the leading cause of morbidity and mortality in the elderly, is caused by inadequate myocardial blood flow. Technology has brought effective means of directly augmenting myocardial blood flow (CABG, PTCA, thrombolysis) and, therefore, providing symptomatic relief and prolongation of useful life in large numbers of patients.

With the evolution of these technologies came the evidence of their measurable benefit to the elderly. As noted above, surgical revascularization can be accomplished in the elderly with a risk/benefit ratio similar to that in much younger patients. Thus, the justification for these volume increases rests on carefully conducted prospective studies, many of which are ongoing, for example, for CABG, PTCA, and thrombolysis.

In concert with the therapeutic interventions for the elderly population, diagnostic technologies have become more sophisticated and precise, fostering appropriate therapeutic recommendations. In addition, diagnostic technologies allow for improved patient management following intervention.

New technologies often stimulate the need for additional technologies. For example, successful coronary thrombolysis leads to further testing to ascertain the extent of residual coronary atherosclerosis and myocardium in jeopardy. Patients developing graft stenosis or progression of native coronary atherosclerosis following coronary bypass surgery may find relief from symptoms with balloon angioplasty rather than from repeat surgery.

At a time when access to appropriate care is of major concern to all, it would be critical to maintain the availability of important procedures of proven efficacy. The word "volume" should not be viewed exclusively as a negative feature of medical care. When volume connotes increased availability of beneficial technology (e.g., resulting in enhanced myocardial blood flow), volume can mean value (e.g., longer productive lives) for Medicare beneficiaries.

Cardiovascular technologies are interrelated and interact with each other toward a common goal: to improve blood flow to and through a vitally important component of human anatomy - the heart.

## ENDNOTES

1. Second International Study of Infarct Survival (ISIS-2)
2. Gruppo Italiano per lo Studio della Streptochinasi nell'Infarto Miocardico (GISSI)
3. Thrombolysis in Myocardial Infarction (TIMI)
4. Third International Study of Infarct Survival (ISIS-3)
4. Angioplasty Compared to Medicine (ACME)
6. Bypass Angioplasty Revascularization Investigation (BARI)
7. Coronary Angioplasty Vs. Bypass Revascularization Investigation (CABRI)
8. Emory Angioplasty Surgery Trial (EAST)
9. German Angioplasty Bypass Investigation (GABI)
10. Randomized Intervention Treatment of Angina (RITA)
11. Coronary Artery Surgery Study (CASS)
12. Veterans Administration
13. European Cooperative Studies

## STATEMENT OF THE DIGESTIVE DISEASE NATIONAL COALITION

The Digestive Disease National Coalition (DDNC) is comprised of twenty-three voluntary groups and professional societies involved with digestive diseases. As a patient oriented coalition, the DDNC supports efforts to control the burgeoning costs of health care and providing wide access to state of the art medicine to those that require it. The DDNC would like to submit for the record information that should be considered as decisions are made relative to volume controls for endoscopic procedures.

It is clear from a variety of sources that endoscopic procedures are being performed at an increasing rate, and that some have suggested that many of these procedures are considered to be "inappropriate." The result of this information has been to focus on endoscopy as an over utilized procedure, subject to both decreased reimbursement and attempts to control volume.

Gastrointestinal endoscopy has been an extremely important advance to individuals with gastrointestinal diseases, having the potential to improve the diagnosis and therapy of these diseases. The Digestive Disease National Coalition desires to maintain the availability of this powerful technology. Hidden in the increasing volume of endoscopic procedures are several important facts: currently, anyone who purchases an endoscope can use it and perform these procedures, and even more importantly the accuracy and complications of these procedures are related to the training and skill of the endoscopist. Endoscopy is a technical skill and requires appropriate training and experience. It has been suggested that up to 50% of currently performed procedures are performed by individual physicians who have never been appropriately trained to perform them! The major physician groups involved with endoscopy (the American Society for Gastrointestinal Endoscopy, the American College of Gastroenterology, and the American Gastroenterological Association) have universally agreed upon credentialling requirements for the performance of gastrointestinal endoscopy.

The Digestive Disease National Coalition strongly recommends that the method to ensure both the availability of competent, safe endoscopy and to control the volume of procedures it through the adoption of the concept of COMPARABLE CREDENTIALLING. That is, all individuals who perform gastrointestinal endoscopy be required to have had appropriate training and that even if performed out of a hospital setting, individuals be required to have hospital approved credentials to perform procedures in their office or an outpatient surgery unit. The DDNC urges Congress to support the adoption of the concept of comparable credentialling.

The coalition recognizes that control of medical costs must happen. The coalition also realizes that our primary desire is to deliver the best and safest medical care to those who require it. Adopting the concept of comparable credentialling will help achieve cost savings and assure patients with digestive diseases that procedures are being done by individuals with appropriate training and skill.

Thank you for considering the views of the Digestive Disease National Coalition.

Statement of the

Renal Physicians Association

The Renal Physicians Association (RPA) is pleased to provide a statement to the Subcommittee on Health, Committee on Ways and Means, for the record of the hearing (May 21, 1991) on the Medicare Volume Performance Standard (MVPS) system, the physician fee update for 1992, and increases in the volume of physician services under Medicare.

RPA is a national physician organization comprised of over 1500 nephrologists. Our purpose and goals are to: 1) insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders; 2) act as a national representative for physicians engaged in the study and management of patients with renal disease and related disorders; and 3) serve as a major resource for the development of national health policy concerning renal disease. As nephrologists, we will focus our statement on physician services provided under Medicare's End-Stage Renal Disease (ESRD) program, specifically the Monthly Capitated Payment (MCP) under which nephrologists receive a fixed payment per month per patient for maintenance dialysis services.

## Volume of Dialysis Services Provided Under the MCP, and the MVPS

Since the focus of this hearing is on the volume of physician services and physician fee updates, it should be made clear that when payments are lowered for dialysis services, nephrologists cannot respond by increasing volume, since the nature of dialysis is such that it can only be provided if medically needed according to accepted criteria. Therefore, any increases in the volume of dialysis services over the years is due not to an inappropriate response in volume on the part of nephrologists, but due to an increase in the number of beneficiaries receiving dialysis, and to increases in the levels of services that those patients need. It should also be noted that services provided under the MCP do not fall within the MVPS, and justifiably so, since an inappropriate volume response is not applicable for dialysis services. Accordingly, RPA will strongly oppose a recent bill introduced by Congressman Donnelly (D-MA) which proposes that payments for services to ESRD patients be capped at, or below the MVPS rate of increase.

## Background on the MCP

A review of the history of physician payment for routine maintenance dialysis services shows that payment levels have not kept pace with the rising costs of practice. Physicians delivering care to patients maintained on chronic dialysis have seen decreases in Medicare reimbursement for their services over the years. A minor exception: the monthly payment established in 1974 (under the Alternative Reimbursement Method) was frozen through 1978, at which time a small increase was granted -- the minimum and maximum basic rates used to multiply the infacility/home rates were each increased by $1.

In 1983, the Monthly Capitated Payment (MCP) was initiated under the End Stage Renal Disease Program (ESRD). This system was structured such that a physician received a capitated payment (a set payment per month per patient) based on an office visit times a multiplier. Those physicians at the maximum payment rate with the average patient mix (17 percent home, 83 percent infacility) experienced, on the average, a decrease of 10.8 percent in reimbursement.

This decrease in average physician payment under the ESRD program has since been followed by further reductions. On March 1, 1986 the MCP was reduced by one percent as the result of Gramm-Rudman sequestration. This was followed later that year by a seven percent reduction required by regulation, a two percent Gramm-Rudman-driven reduction in 1989, and a final further Gramm-Rudman-driven reduction of 1.42 percent on April 1, 1990. While other primary care services have been subject to Gramm-Rudman reductions as well, these have been offset through the benefits of the Medicare Economic Index (MEI), an update mechanism which is not applied to the MCP.

## The Need to Define the Bundle of Services Captured Under the MCP

A related problem, and one which continually exacerbates the situation created by the lack of an update for the MCP, is the definition of those services which are actually covered by the MCP. There is a great deal of confusion between various carriers, and HCFA headquarters, as to what these services are. It therefore depends on the part of the country in which a physician practices as to what will, or will not be included under the MCP.

Current policy is that anything that is totally related to renal failure is covered by the MCP. This somewhat vague policy creates much confusion. When a patient is being dialyzed or otherwise treated for renal failure, many complications involving other organ systems can arise. Sometimes a complication will be a clear cut case that it is directly renal-related, and therefore covered by the

MCP. However, there are many cases where the line is not clear – is it renal-related or not? Should the service fall under the MCP or not?

Finally, because of the lack of clarity as to what services actually fall under the MCP, there has been a tendency by HCFA to continually bundle more and more services under the MCP, without any attendant increase or update. As physicians are expected to provide more and more services under the MCP, the need for an update becomes imperative.

RPA has been working with HCFA, laying the groundwork for developing a clear definition of the bundle of services captured under the MCP. As we work toward a permanent means of providing an update mechanism for the MCP, it will be equally as important to define as exactly as possible, what these services are.

## The Need for an Update of the MCP

Continual reductions in the MCP must be compared against the costs of medical practice. These cost have risen sharply in recent years, and continue to do so. The Consumer Price Index (medical care) rose 29 percent over the period 1983 - 1988. Physicians' Mean Professional Expenses rose 65 percent over this same period. The MEI, an update mechanism not applied to the MCP, increased by 116 percentage points over the years 1983 - 1990. Yet, during this same time period the MCP decreased to a point that is currently 66.3 percent of its rate as originally established in 1983 (please see attached chart).

Given the strong likelihood that physician practice costs will continue to increase steadily, the gap between the MCP and the actual cost of providing maintenance dialysis services will continue to widen. RPA is concerned that this continued erosion of Medicare benefits will force compromises in the availability of services to patients who are Medicare beneficiaries.

As a long-term goal, RPA is working with the Physician Payment Review Commission to ensure that a means of regularly updating the MCP be built in. However, this will, take time. In the meantime, patient demands and practice costs will rise. It is therefore imperative that the Health Care Financing Administration (HCFA), who has the authority under statute to grant an update for the MCP, do so immediately; and that the Congress act to ensure that HCFA does. The ESRD program as a whole, and the MCP specifically, have too long been ignored. We seek only what other services have received on a regular, systematic basis – **that is recognition of the increasing level of services we provide in an environment of increasing costs, by a regular update**. This will give nephrologists paid under the MCP the means needed to continue to provide the highest quality of care.

## Conclusion and Summary

1. Reimbursement for nephrologists' maintenance dialysis services, provided under the MCP, has consistently been either frozen or reduced since 1986, as discussed above and reflected in the attached chart. In addition, while other physician services receive an annual update applied through the Medicare Economic Index (MEI), there is no mechanism in place to provide any type of automatic cost-of-living adjustments for physician payment under the ESRD program. In the press release announcing this hearing, Mr. Stark noted that "the cost of Medicare physician services grew by 12.1 percent between 1986 and 1989." However, during this same time the MCP was reduced by 10 percent due to budget cuts. Between 1983 and 1990 the MCP was reduced by over one-third.

2. When nephrologists' fees go down, the volume of dialysis services cannot go up inappropriately, as the nature of dialysis is such that it can only be provided when medically necessary according to established medical criteria.

3. Congress and HCFA should provide an appropriate update for physicians who are not "gaming the system" by inappropriately increasing volume. Given that nephrologists are rendering more services under that same capitated amount, while payments for dialysis services provided by nephrologists have continued to decline, Congress should take action to provide an appropriate update for these services. Already, Congress has acted by reducing fees for services which are overvalued, and has established an MVPS system to control volume. We believe Congress should be equally concerned with establishing

an appropriate means of providing an update for nephrologists' services. For too long, nephrology services have been the "orphan child" of medical reimbursement.

The Renal Physicians Association thanks the Subcommittee for its attention to this very important matter. We stands ready to assist you in achieving an appropriate update for the MCP and clarifying any related issues.

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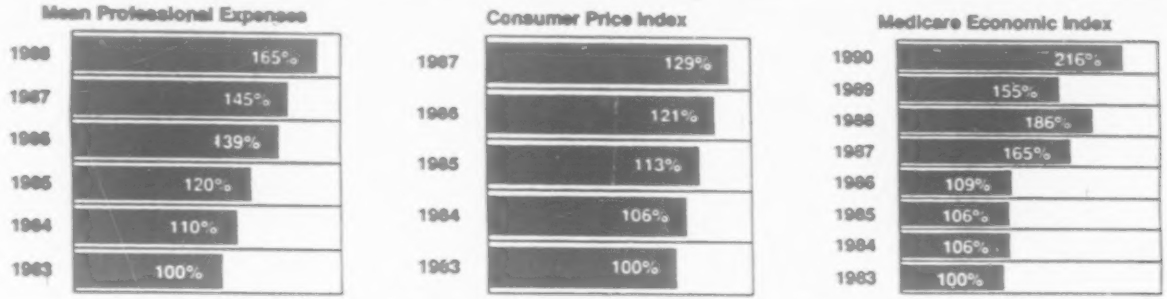
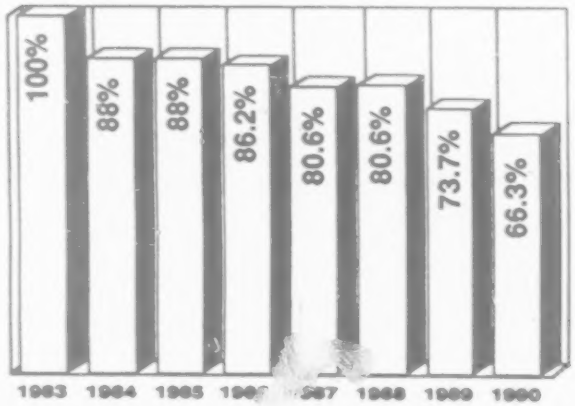
## Monthly Capitated Payment Compared To MPE, CPI, and MEI




## Monthly Capitated Payment




Source: Renal Physicians Association 1990.